INITIAL STATEMENT OF REASONS

California Code of Regulations
Title 9. Rehabilitative and Developmental Services
Division 1. Department of Mental Health
Chapter 11. Medi-Cal Specialty Mental Health Services

Description of the Public Problem, Administrative Requirements, and Other Conditions and Circumstances these Regulations Are Intended to Address:

Existing law (Welfare and Institutions Code Section 5775 (f) provides regulatory authority for implementation of Section 1810.100, et seq, Title 9 California Code of Regulations. It is intended that**,** upon the adoption of the new regulations put forth in this package, existing regulations in Title 9 Section 1810.100, et seq will be repealed.

This regulation package adopts Sections 1810.100 through 1850.505, Title 9, California Code of Regulations (CCR) to implement, interpret, and make specific provisions of Assembly Bill (AB) 757 (Chapter 633, Statutes of 1994). Specifically, these regulations implement Sections 5775 through 5780, and Sections 14680 through 14685 of the Welfare and Institutions Code, which provides for the phased implementation of managed mental health care for Medi-Cal beneficiaries through fee-for-service or risk-based contracts with mental health plans (MHPs). These regulations establish requirements for the second phase of implementation. This phase combines the first phase, which consolidated the authorization and funding of Medi-Cal reimbursed psychiatric inpatient hospital services, with the consolidation of the authorization and funding of other specialty mental health services. The primary goal of this program change is to create improved quality of care and access to specialty mental health services for Medi-Cal beneficiaries in the most cost-effective manner possible.

In addition to AB 757, the program implemented in these regulations is governed by the conditions of a federal waiver of specific provisions of Title XIX of the Social Security Act. The federal waiver was originally approved by the federal Health Care Financing Administration (HCFA) in May 1995 as the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation program. (Please note that HCFA was renamed the Centers for Medicare and Medicaid Services (CMS) in 2001. Any references to HCFA in this rulemaking now apply to CMS.) HCFA/CMS approved the renewal, modification and renaming of this waiver as the Medi-Cal Specialty Mental Health Services Consolidation waiver program on September 5, 1997, a second renewal on November 16, 2000, and a third renewal on April 24, 2003. The waiver program as approved April 24, 2003 will be in effect through April 27, 2005. CMS may approve additional renewals for subsequent two-year periods. The State submitted a fourth waiver renewal request to CMS on January 27, 2005. On March 26, 2005, CMS approved this fourth waiver request, which will begin April 1, 2005, and extend through March 31, 2007.

The purpose of the Medi-Cal Specialty Mental Health Services regulations is to standardize and make consistent the requirements for all MHPs that participate in the Medi-Cal Specialty Mental Health Services Consolidation program. To accomplish this,

the Department of Mental Health is adopting Chapter 11, “Medi-Cal Specialty Mental Health Services,” in Division 1 of Title 9, CCR.

The adoptions of these regulations is the only means of establishing necessary requirements for Medi-Cal specialty mental health services as required in statute, and of ensuring successful transition to a mental health care delivery system that will eventually provide Medi-Cal beneficiaries with access to mental health care through full risk MHPs.

These regulations use the term “mental illness” to describe the conditions the Medi-Cal Specialty Mental Health Services Consolidation program is designed to treat. When the regulations refer to the clinical diagnoses covered by the program, the term “mental disorder” is used to be consistent with the terminology used by clinicians to describe specific mental illnesses.

Specific necessity for each section is discussed below:

Subchapter 1. General Provisions

Article 1. General

Section 1810.100. General Program Description.

Specific Purpose: Section 1810.100 describes the overall scope of the regulations included in this Chapter, setting the basic parameters of the Medi-Cal Specialty Mental Health Services Consolidation program.

Rationale for Necessity: This Section is necessary to clarify that the regulations in this Chapter are implemented exclusively through a contract between Department of Mental Health (Department) and MHPs as defined. It further explains that MHPs under contract with the Department are responsible for provision of beneficiaries’ specialty mental health services regardless of financial allocations. The Section makes it clear that once the contract between the Department and an MHP is in place, all Medi-Cal beneficiaries of that county may only receive Medi-Cal funded specialty mental health services through the MHP. The Section also explains that beneficiaries may obtain Medi-Cal services not covered by the MHP under the provisions of the regulations that govern the regular Medi-Cal program to ensure that beneficiaries and providers understand that this Chapter does not affect other Medi-Cal benefits.

Section 1810.110. Applicability of Laws and Regulations and Program Flexibility.

Specific Purpose: Section 1810.110 describes the relationship between this Chapter and other laws, regulations, and guidelines governing the Medi-Cal program. The Section requires that contracts between the MHP and providers are consistent with the requirements of the Chapter. The Section also provides authority for the Department to grant waivers and other exceptions to specific requirements of the regulations in this Chapter.

Rationale for Necessity: Subsection (a) is necessary to make it clear that, since the mental health managed care program is a Medi-Cal program, MHPs must comply with existing federal and State requirements governing the Medi-Cal program.

Subsection (b) includes a specific statement that MHPs must comply with confidentiality requirements in federal and State law and regulation to clarify that MHPs must comply with these requirements. Although Title 9, CCR, Subdivision 1, Chapter 11, does not regulate confidentiality issues, these issues are of special concern to individuals receiving mental health services, making such clarification necessary. State and federal confidentiality laws and regulations are not specifically cited because these areas of law and regulation are contained in various areas of law.

Subsection (c) is necessary to make it clear that the protections provided to beneficiaries and providers in this Chapter cannot be nullified or superseded by the terms of contracts between MHPs and providers.

Subsection (d) is necessary to allow the Department the flexibility to implement field test programs authorized by Section 5719.5 of the Welfare and Institutions Code. These field tests provide an opportunity for the Department and MHPs to test components of a capitated Medi-Cal managed mental health care system. Results from the field tests are expected to facilitate the implementation of a capitated rate payment system for the MHPs, rather than the fee-for-service MHP payment system established by Section 5778 of the Welfare and Institutions Code and implemented by this Chapter. Implementation of a capitated rate payment system is the final phase of the Medi-Cal Managed Mental Health Care program, which was authorized by Welfare and Institutions Code, Section 5779, and described in more detail in the Department's publication, "Medi-Cal Managed Mental Health Care," issued June 1, 1994. Currently field test programs operate in San Mateo and Solano Counties. Section 5778(c) of the Welfare and Institutions Code authorizes the Department to allow MHPs operating under field test authority to follow the requirements established for the field test rather than the requirements of the Section 5778 of the Welfare and Institutions Code and this Chapter, when there is a conflict in requirements. Any waivers granted by the Department must be consistent with other federal and State Medi-Cal requirements and incorporated into the contract between the MHP and the Department. This Subsection also makes it clear that specific requirements of the regulations in Subchapter 5, covering beneficiary, provider and other MHP problem resolution processes may not be waived.

Article 2. Definitions, Abbreviations and Program Terms

In general, this Article defines terms that have meanings other than those covered by standard dictionary definitions of the terms. The definitions, abbreviations and program terms contained in this Article are used in more than one subchapter of these regulations. When terms requiring a regulatory definition are used only in one subchapter, article or section, the definitions are provided separately in that subchapter, article or section.

Section 1810.200. Action.

Specific Purpose: Section 1810.200 defines a key component of the beneficiary problem resolution and Notice of Action processes.

Rationale for Necessity: This definition is necessary to conform this Chapter to Title 42, Code of Federal Regulations (CFR), Part 438, which defines "action" at Section 438.400 to be used to identify specific actions by managed care plans that are subject to appeal and fair hearing and require a Notice of Action to the beneficiary. In addition to the actions specified in the federal definition that apply to the Medi-Cal Specialty Mental Health Services Consolidation program, the Section also includes at Subsection (b) a determination by the MHP or its providers that specific medical necessity criteria have not been met and the beneficiary is not entitled to any specialty mental health services from the MHP. The Department has determined that this action must also be subject to appeal and fair hearing and require a Notice of Action. A Notice of Action to beneficiaries is important in the action in Subsection (b) because it is most likely to occur on the beneficiary's initial contact with the MHP or its providers, when beneficiaries may not be fully aware of the mechanisms available to resolve disputes.

Section 1810.201. Acute Psychiatric Inpatient Hospital Services.

Specific Purpose: Section 1810.201 defines a type of psychiatric inpatient hospital service available to Medi-Cal beneficiaries in the program implemented by these regulations.

Rationale for Necessity: This definition is used consistently throughout these regulations to describe one of two levels of inpatient hospital services, the other level being administrative day services, as defined in Section 1810.202. The distinction is required because the regulations establish specific rates of payment and authorization procedures for the two levels of service.

Section 1810.202. Administrative Day Service.

Specific Purpose: Section 1810.202 defines a type of psychiatric inpatient hospital service available to Medi-Cal beneficiaries in the program implemented by these regulations.

Rationale for Necessity: This definition is used consistently throughout these regulations to describe one of two levels of inpatient hospital services, the other level being acute psychiatric inpatient hospital services, as defined in Section 1810.201. The distinction is required because the regulations establish specific rates of payment and authorization procedures for the two levels of service.

Section 1810.203. Adult Residential Treatment.

Specific Purpose: Section 1810.203 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of the specialty mental health services covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle Mental Health Medi-Cal Program Services available to beneficiaries not covered by this Chapter. Variations from the definitions in Title 22, Section 51341, have been made to improve clarity by deleting two undefined terms that are not essential to defining the service, "therapeutic community" and "structured package program." The definition also lists service activities that may be components of the service. An exhaustive list is not provided because specific service activities vary on a case-by-case basis.

1810.203.5. Appeal.

Specific Purpose: Section 1810.203.5 defines a key component of the MHP beneficiary problem resolution processes described in 1850.205.

Rationale for Necessity: This definition is necessary to avoid duplicative cross referencing of Sections 1850.205 and 1850.207 when the term “appeal” is used in other regulations in this Chapter and to differentiate between the definitions of and uses of the terms “grievance” and “expedited appeal” as defined in Sections 1810.218.1 and 1810.216.1.

Section 1810.204. Assessment.

Specific Purpose: Section 1810.204 defines a type of service activity that may be provided as a component of specific specialty mental health services as described under the definition of the services.

Rationale for Necessity: This definition is necessary to provide a clear description of the assessment component of specialty mental health services covered by the MHPs. Since this service activity is a component of many of the specialty mental health services, a separate definition prevents the unnecessary duplication that might otherwise be required in the individual service definitions. The definition of the service activity provides representative examples of the types of activities included under the particular service activity. An exhaustive list is not provided because specific service activities vary on a case-by-case basis.

Section 1810.205. Beneficiary.

Specific Purpose: Section 1810.205 defines those persons who may be eligible for specialty mental health services under this Chapter.

Rationale for Necessity: This Section is necessary to make it clear that beneficiary as used in this Chapter applies only to persons who are Medi-Cal eligible under the regulations applicable to the Medi-Cal program as a whole.

Section 1810.205.1. Border Community.

Specific Purpose. Section 1810.205.1 specifies the communities outside the State that routinely serve beneficiaries.

Rationale for Necessity: This Section is necessary because the responsibilities of the MHP for out-of-state services cannot be clearly understood unless border communities are clearly defined. The MHP is responsible for out-of-state services only when they are provided in border communities (see Section 1810.355). The concept of border communities is also considered in the rate setting process for psychiatric inpatient hospital services (Section 1820.110).

Section 1810.205.2. Client Plan.

Specific Purpose. Section 1810.205.2 defines the plan for specialty mental health services that must be developed for beneficiaries.

Rationale for Necessity: This Section is necessary to provide a definition of the plans for providing specific specialty mental health services to beneficiaries. The term "client plan" was selected, rather than another term such as "treatment plan" to provide emphasis to requirements in this Chapter and in the contract between the Department and the MHP that beneficiaries be involved in the development of these plans.

Section 1810.206. Collateral.

Specific Purpose: Section 1810.206 defines a type of service activity that may be provided as a component of specific specialty mental health services as described under the definition of the services.

Rationale for Necessity: This definition is necessary to provide a clearer description of this component of specialty mental health services covered by the MHPs. Since this service activity is a component of many of the specialty mental health services, a separate definition prevents the unnecessary duplication that might otherwise be required in the individual service definitions. A collateral service activity is an activity provided to significant support persons in the beneficiary's life, rather than to the beneficiary. The Medi-Cal program provides services only to eligible beneficiaries, so the definition of collateral service activities must be clear that the overall goal of collateral service activities is to help improve, maintain, and restore the beneficiary’s mental health status through interaction with the significant support person. There must

be a clear linkage between the collateral service activity and the beneficiary's treatment goals as expressed in the client plan.

Section 1810.207. Contract Hospital.

Specific Purpose: Section 1810.207 establishes a specific category of hospitals based upon the existence of an agreement with an MHP established in accordance with these regulations.

Rationale for Necessity: This Section is necessary because there are specific provisions of this Chapter that apply only if the hospital has a contract with the MHP.

Section 1810.208. Crisis Residential Treatment Service.

Specific Purpose: Section 1810.208 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of this specialty mental health service covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the language in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this Chapter. Variations from the definitions in Title 22, Section 51341, have been made to improve clarity by deleting an undefined term that is not essential to defining the service, "structured, packaged program." The Title 22, Section 51341, requirement that "interventions that focus on symptom reduction shall also be available" was deleted as inappropriate for a definition. Instead the definition lists service activities that may be components of the service. An exhaustive list is not provided because specific service activities vary on a case-by-case basis.

Section 1810.209. Crisis Intervention.

Specific Purpose: Section 1810.209 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of this specialty mental health service covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity and to make a necessary distinction between Title 22, Section 51341 and this Chapter regarding the definition of emergency. The definition of "crisis intervention" in Title 22 uses the term "quick emergency response" in a way that is not consistent with the definition of an emergency

psychiatric condition in Section 1810.216. The definition of an emergency psychiatric condition in the Section 1810.216 is essential in assuring compliance with federal requirements regarding authorization of emergency services (see the statement of reasons for Section 1810.216). The definition lists service activities, one of which must be a component of the service. An exhaustive list is not provided because specific service activities vary on a case-by-case basis.

Section 1810.210. Crisis Stabilization.

Specific Purpose: Section 1810.210 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of this specialty mental health service covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity and delete provisions that are not appropriate to a definition. The definition in Title 22 does not operate solely as a definition, but also provides requirements, e.g., that the service be immediate and face-to-face, that are not appropriate to a definition. Title 22, Section 51341 definitions for Crisis Stabilization—Urgent Care and Crisis Stabilization—Emergency Room have been combined because the distinction between the types of sites at which the each of these services had to be delivered is unnecessary, since the rate and the service is the same at either site. The definition lists service activities, one of which must be a component of the service. An exhaustive list is not provided because specific service activities vary on a case-by-case basis.

Section 1810.211. Cultural Competence.

Specific Purpose: Section 1810.211 defines a particular form of competence applicable in situations where individuals from diverse cultural backgrounds may be involved.

Rationale for Necessity: This Section is necessary to clarify the intent of authorizing legislation, which requires that MHPs provide culturally competent services to the extent feasible [Welfare and Institutions Code, Section 14684(h)] but does not define the term. This definition was drawn from one used nationally, developed by researchers at the Georgetown University Development Center (see “Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed,” March 1989) and from Welfare and Institutions Code Section 5600.2(g).

Section 1810.212. Day Rehabilitation.

Specific Purpose: Section 1810.212 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of this specialty mental health service covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity by making the definition consistent with the structure of other service definitions in this Chapter in terms of references to beneficiaries rather than individuals and use of defined service activities to describe the content of the service in more detail. The list of service activities includes those that may be components of the service. An exhaustive list is not provided because specific service activities vary on a case-by-case basis.

Section 1810.213. Day Treatment Intensive.

Specific Purpose: Section 1810.213 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of this specialty mental health service covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity by making the definition consistent with the structure of other service definitions in this Chapter in terms of references to beneficiaries rather than individuals and use of defined service activities to describe the content of the service in more detail. The list of service activities includes those that may be components of the service. An exhaustive list is not provided because specific service activities vary on a case-by-case basis.

Section 1810.214. Department.

Specific Purpose: Section 1810.214 establishes the specific department of State government to which the term will refer in these regulations, which is the Department of Mental Health.

Rationale for Necessity: This section is necessary to shorten references to the Department of Mental Health in this Chapter while preventing confusion with other State departments.

Section 1810.214.1. Disproportionate Share Hospital (DSH).

Specific Purpose: Section 1810.214.1 defines a specific type of hospital.

Rationale for Necessity: This Section is necessary because these regulations establish contract requirements for MHPs for different classes of hospitals based upon the hospital's history of providing of services to Medi-Cal beneficiaries and other low-income individuals. One class of hospitals is disproportionate share hospitals. The definition is consistent with federal and State Medi-Cal definitions.

Section 1810.215. Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Specialty Mental Health Services.

Specific Purpose: Section 1810.215 defines a type of specialty mental health service covered by the MHPs.

Rationale for Necessity: This definition is necessary to provide a specific description of this specialty mental health service covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4. This Section provides a necessary distinction between Early and Periodic Screening, Diagnosis and Treatment (EPSDT) supplemental services covered by the regular Medi-Cal program and such services covered by MHPs, i.e., services that are clearly specialized mental health treatment services, rather than physical health care treatment services. This Section is necessary to clarify that only the State Department of Health Services, as the State department responsible for Medi-Cal policy, has the authority decide whether or not a service qualifies as an EPSDT supplemental service. Specific EPSDT supplemental specialty services are not defined because the definition is intended to utilize the flexibility in federal law governing the EPSDT program, which requires that any legitimate service that may correct or ameliorate the condition of a beneficiary under 21 years of age must be covered by the Medi-Cal program. One EPSDT supplemental service, called therapeutic behavioral service, has been established through a preliminary injunction in the case of Emily Q. v. Bontá (an attachment to DMH Information Notice No. 99-09). The final Judgment and Permanent Injunction in the case was issued May 10, 2001 and the case continues to be under the jurisdiction of the Court. The Department is studying the issues raised by the case and expects to promulgate regulations specific to this service in the future. Pending the adoption of regulations, MHPs are bound by the Judgment and Permanent Injunction.

Section 1810.216. Emergency Psychiatric Condition.

Specific Purpose: Section 1810.216 defines the clinical conditions that constitute an emergency under this Chapter.

Rationale for Necessity: This definition is necessary to provide clear direction to MHPs and providers about what constitutes an emergency under this Chapter. This Chapter limits the ability of MHPs to prior authorize services when an emergency psychiatric condition exists, consistent with federal laws and regulations applicable to

this Chapter. Definitions of emergencies commonly used in the health care industry focus on medical, rather than psychiatric conditions and, therefore, would not be applied consistently by MHPs or providers. The definition is based on the definition established in January 1995 in Section 1769, for psychiatric inpatient hospital services, but has been modified to cover the additional specialty mental health services covered by this Chapter.

Section 1810.216.2. Expedited Appeal.

Specific Purpose: Section 1810.216.2 defines a key component of the MHP beneficiary problem resolution process as described in Section 1850.205.

Rationale for Necessity: This definition is necessary to avoid duplicative cross referencing of Section 1850.205 when the term "expedited appeal" is used in other regulations in this Chapter and to differentiate between the definitions of and uses of the terms "grievance" and "appeal" as defined in Sections 1810.218.1 and 1810.203.5.

Section 1810.216.4. Expedited Fair Hearing.

Specific Purpose: Section 1810.216.4 defines a specific component of the problem resolution process available to beneficiaries under this Chapter.

Rationale for Necessity: This definition is necessary to differentiate the meaning of expedited fair hearings from fair hearings as used in this Chapter and to establish that references to expedited fair hearings in this Chapter mean the expedited fair hearing process available to all beneficiaries under the Medi-Cal program, and not a separate process established by this Chapter. .

Section 1810.216.6. Fair Hearing.

Specific Purpose: Section 1810.216.6 defines a specific component of the problem resolution process available to beneficiaries under this Chapter.

Rationale for Necessity: This definition is necessary to establish that references to fair hearings in this Chapter mean the fair hearing process available to all beneficiaries under the Medi-Cal program, and not a separate process established by this Chapter.

Section 1810.216.8. Federal Financial Participation (FFP).

Specific Purpose: Section 1810.216.8 defines the term commonly used to describe the federal matching funds available under the Medi-Cal program.

Rationale for Necessity: This definition is necessary because the term, although commonly used within the Medi-Cal program, may not be generally understood.

Section 1810.217. Fee-for-Service/Medi-Cal Hospital.

Specific Purpose: Section 1810.217 defines a specific type of hospital covered by this Chapter.

Rationale for Necessity: This Section is necessary to distinguish between Fee-for-Service/Medi-Cal hospitals and Short-Doyle/Medi-Cal hospitals for the purpose of rate setting, claiming FFP and authorization procedures. This distinction is a component of the Psychiatric Inpatient Hospital Services Consolidation waiver request as it was originally approved by HCFA in March 1995 and in its current form, the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request approved by HCFA in November 2000. The regulations must be consistent with the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request approved by HCFA in November 2000, which permits the operation of this program under federal law.

Section 1810.218. Fiscal Intermediary.

Specific Purpose: Section 1810.218 defines the source of claims processing and payment for certain services covered by the MHP.

Rationale for Necessity: This definition is necessary to make it clear that the fiscal intermediary referenced in this Chapter is the fiscal intermediary used by the regular Medi-Cal program.

Section 1810.218.1. Grievance.

Specific Purpose: Section 1810.218.1 defines a term that is a key component of the beneficiary problem resolution process as described in Section 1850.205.

Rationale for Necessity: This definition is necessary to avoid duplicative cross referencing of Section 1850.205 and 1850.206 when the term “grievance” is used in other regulations in this Chapter.

Section 1810.218.2. Group Provider.

Specific Purpose: Section 1810.218.2 defines a type of provider that may provide services under this Chapter.

Rationale for Necessity: This regulation is necessary to distinguish among individual, group and organizational providers for the purposes of this Chapter. The distinction is necessary because rate setting and claiming FFP requirements for individual and group providers are different under this Chapter from the requirements applicable to organizational providers, consistent with the terms of the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request as approved by HCFA in November 2000. Organizational provider defines entities that have historically participated in the Medi-Cal program as Short-Doyle/Medi-Cal providers on a cost reimbursement or negotiated rate basis involving submission of annual cost reports.

These requirements will continue under this Chapter (sections 1830.105 and 1840.105). Individual provider and group provider defines providers that have historically participated in the Medi-Cal program on the basis of fee-for-service rates established by the State with no requirement for annual cost reports and that, under this Chapter, are not required to submit cost reports to the Department (Section 1840.105). These providers, absent a contract with the MHP, will be paid at the regular fee-for-service Medi-Cal rate applicable to the service provided (Section 1830.105).

This definition does not in and of itself limit the ways in which providers may provide services under this Chapter. A single provider may meet the definition of a group provider or the definition of organizational provider depending on the terms of the contract between the MHP and the provider or, absent a contract, on the way in which an individual service was delivered. Providers who deliver services as staff or contractors of an organizational provider are not precluded from also delivering services as an individual or group provider solely based on the definitions in this Article. Group providers have been defined separately from individual providers to distinguish group providers more clearly from organizational providers, since group providers include categories that might otherwise be assumed to be organizational providers, such as clinics and hospital outpatient departments.

Section 1810.219. Hospital.

Specific Purpose: Section 1810.219 defines hospital as used in this Chapter.

Rationale for Necessity: This definition is necessary to clarify the types of institutions covered by the regulations in this Chapter applicable to hospitals and psychiatric inpatient hospital services. This definition allows the term hospital as used in this Chapter to include psychiatric health facilities that have been certified by the Medi-Cal program to provide psychiatric inpatient hospital services. These psychiatric health facilities are not hospitals under definitions typically used in the health care industry, but the requirements of this Chapter applicable to psychiatric inpatient hospital services are intended to apply to them. Their inclusion in the definition allows for a clearer reference in applicable regulations.

Section 1810.220. Hospital-Based Ancillary Services.

Specific Purpose: Section 1810.220 clarifies what is included in hospital-based ancillary services provided as part of all psychiatric inpatient hospital services covered by MHPs.

Rationale for Necessity: This Section is necessary to establish a definition of what is included in psychiatric inpatient hospital services rates that is applicable statewide. Psychiatric inpatient hospital services rates negotiated by MHPs under these regulations may be applicable to other MHPs using the same hospital. Negotiated rates also form the basis of the rates established by the Department for non-contract hospitals. The ancillary services included have a substantial impact on total cost of hospitalization and must be consistent statewide. Two services included under hospital-based ancillary services, electroconvulsive therapy (ECT) and magnetic resonance

imaging (MRI), have been specifically included in the definition because they may represent a significant cost factor and may not be universally understood to be included. Prescription drugs have been specifically included to clarify that these drugs are covered by the MHP as part of psychiatric inpatient hospital services, even though they are excluded when they are provided as a separate service (Section 1810.355).

Section 1810.221. Implementation Plan.

Specific Purpose: Section 1810.221 provides a general definition of the document the MHP must prepare pursuant to Section 1810.310, which describes the requirements of the Implementation Plan in detail.

Rationale for Necessity: This definition is necessary to avoid duplicative cross-referencing of Section 1810.310 when the term "Implementation Plan" is used in other regulations in this Chapter.

Section 1810.222. Individual Provider.

Specific Purpose: Section 1810.218.2 defines a type of provider that may provide services under this Chapter.

Rationale for Necessity: This regulation is necessary to distinguish among individual, group and organizational providers for the purposes of this Chapter. The distinction is necessary because rate setting and claiming FFP requirements for individual and group providers are different under this Chapter from the requirements applicable to organizational providers, consistent with the terms of the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request approved by HCFA in November 2000. Organizational provider defines entities that have historically participated in the Medi-Cal program as Short-Doyle/Medi-Cal providers on a cost reimbursement or negotiated rate basis involving submission of annual cost reports. These requirements will continue under this Chapter (sections 1830.105 and 1840.105). Individual provider and group provider define providers that have historically participated in the Medi-Cal program on the basis of fee-for-service rates established by the State with no requirement for annual cost reports and that, under this Chapter, are not required to submit cost reports to the Department (Section 1840.105). These providers, absent a contract with the MHP, will be paid at the regular fee-for-service Medi-Cal rate applicable to the service provided (Section 1830.105).

This definition does not in and of itself limit the ways in which providers may provide services under this Chapter. A single provider may meet the definition of a group provider or the definition of organizational provider depending on the terms of the contract between the MHP and the provider or, absent a contract, on the way in which an individual service was delivered. Providers who deliver services as staff or contractors of an organizational provider are not precluded from also delivering services as an individual provider solely based on the definitions in this Article.

Section 1810.222.1. Institution for Mental Diseases.

Specific Purpose: Section 1810.222.1 defines a specific category of hospital, nursing facility or other institution.

Rationale for Necessity: This regulation is necessary to identify a specific type and size of institution that is not eligible for reimbursement of FFP under the Medi-Cal program unless the beneficiaries served meet specific age requirements. The definition is based on the federal definition contained in Title 42, Code of Federal Regulations, Section 435.1009.

Section 1810.223. Licensed Mental Health Professional.

Specific Purpose: Section 1810.223 lists the types of licensed practitioners of the healing arts that would typically be used to provide specialty mental health services.

Rationale for Necessity: This regulation is necessary to provide a single term for use in this Chapter to establish authorization and staffing standards when licensed personnel are required, rather than listing individual types of practitioners separately.

Section 1810.223.5. Medi-Cal Eligibility Data System (MEDS).

Specific Purpose: Section 1810.223.5 defines the Department of Health Services database that holds electronic information about Medi-Cal eligibility.

Rationale for Necessity: This regulation is necessary because the MEDS database is the major vehicle by which the MHPs determine a beneficiary's eligibility for Medi-Cal specialty mental health services and the MHP responsible for authorization and payment of services.

Section 1810.224. Medi-Cal Managed Care Plan.

Specific Purpose: Section 1810.224 defines the entities contracting with the State Department of Health Services to provide services to enrolled Medi-Cal beneficiaries.

Rationale for Necessity: This regulation is necessary to provide a single term for use in this Chapter to establish the MHPs' obligations for coordination of care for beneficiaries who obtain health care through one of the several managed care programs administered by the State Department of Health Services. The definition includes programs commonly referred to as the Two-Plan Model, County Organized Health Systems, Prepaid Health Plans, Primary Care Case Management Plans, Fee-for-Service Managed Care Networks, and Geographic Managed Care Plans.

Section 1810.225. Medication Support Services.

Specific Purpose: Section 1810.225 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of the specialty mental health services covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries who are not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity by making the definition consistent with the structure of other service definitions in this Chapter by using defined service activities to describe the content of the service in more detail. The list of service activities includes those that are likely to be components of the service. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis. The reference in Title 22, Section 51341 to the staff person delivering the services has been deleted, since the issue is covered in Section 1840.346, which addresses staffing requirements for medication support services.

Section 1810.225.1. Memorandum of Understanding (MOU).

Specific Purpose: Section 1810.225.1 describes a specific written agreement between MHPs and Medi-Cal managed care plans.

Rationale for Necessity: This definition is necessary to avoid duplicative cross-referencing of Section 1810.370 when the terms “Memorandum of Understanding” or “MOU” are used in other regulations in this Chapter.

Section 1810.226. Mental Health Plan (MHP).

Specific Purpose: Section 1810.226 names and describes the entity that will be designated by the Department to operate, on a local level, the program implemented by these regulations.

Rationale for Necessity: This regulation is necessary because it establishes that this term is used in the same way in these regulations as it was used in AB 757 (Chapter 633, Statutes of 1994), which enacted sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code. This regulation is also necessary because it clarifies that MHPs may contract and/or arrange services for beneficiaries in addition to direct provision of services by the MHP.

Section 1810.227. Mental Health Services.

Specific Purpose: Section 1810.227 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of the specialty mental health services covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22,

Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries who are not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity. The term "maximum" in "maximum reduction of mental disability" and the description of the services as directed toward client goals do not appear in this Section because this would imply a responsibility on the part of the MHPs that is not appropriate to this definition. This responsibility is covered elsewhere in this Chapter, e.g., in Section 1810.345, "Scope of Covered Specialty Mental Health Services." The definition is made consistent with the structure of other service definitions in this Chapter by using defined service activities to describe the content of the service in more detail. The list of service activities includes those that are likely to be components of the service. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis. The reference in Title 22, Section 51341 to the staff person delivering the services has been deleted, since the issue is covered in Section 1840.346, which addresses staffing requirements for medication support services.

Section 1810.228. MHP of Beneficiary.

Specific Purpose: Section 1810.228 defines the MHP responsible for the provision of services under this Chapter to an individual beneficiary.

Rationale for Necessity: This regulation is necessary to establish the county of responsibility code as contained in the Medical Eligibility Data System (MEDS) files maintained by the State Department of Health Services as the determining factor in matching beneficiaries with the MHP responsible to provide them with specialty mental health services under this Chapter. County of responsibility codes are added to MEDS as part of the normal Medi-Cal eligibility determination process in accordance with Medi-Cal regulations in Title 22 and the same information can be accessed by all MHPs and Medi-Cal providers. The definition also cross-references the regulation governing disputes between MHPs regarding the MHP of the beneficiary to specify the only exception to the use of MEDS.

Section 1810.229. MHP Payment Authorization.

Specific Purpose: Section 1810.229 defines the authorization given by an MHP to a provider for payment of specialty mental health services under this Chapter.

Rationale for Necessity: The regulation is necessary to provide a single term for the authorization of specialty mental health services by MHPs for use in the title of sections 1820.215, 1820.220, 1820.225, 1820.230, 1830.215 and 1830.250 governing MHP authorization processes and to avoid duplicative cross-referencing within regulations. MHP payment authorization is comparable to the term treatment authorization generally used by the regular Medi-Cal program. A separate term was selected to distinguish the program under this Chapter from the regular Medi-Cal program. The authorization is called a payment, rather than a treatment authorization because the term has been in use since January 1995 in the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation waiver program (see Title 9, CCR, Section 1715). The Department determined that changing the term for psychiatric inpatient hospital services or using a

different term for the additional services added by this Chapter would create unnecessary confusion.

Section 1810.230. Non-contract Hospital.

Specific Purpose: Section 1810.230 defines a type of a hospital under this Chapter.

Rationale for Necessity: This regulation is necessary to provide a single term of reference for hospitals that do not have a contract with the MHP for psychiatric inpatient hospital services. Regulations in this Chapter allow an MHP to restrict planned admissions of beneficiaries to contract hospitals and to transfer beneficiaries admitted to non-contract hospitals in an emergency to contract or MHP owned hospitals as soon as the patient is stable.

Section 1810.230.5. Notice of Action.

Specific Purpose: Section 1810.230.5 defines a type of notice to beneficiaries required under this Chapter.

Rationale for Necessity: This regulation is necessary to identify a specific type of notice that MHPs must provide to beneficiaries when the conditions described in Section 1850.210 exist.

Section 1810.231. Organizational Provider.

Specific Purpose: Section 1810.231 defines a type of provider that may provide services under this Chapter.

Rationale for Necessity: This regulation is necessary to distinguish among individual, group and organizational providers for the purposes of this Chapter. The distinction is necessary because rate setting and claiming FFP requirements for individual and group providers are different under this Chapter from the requirements applicable to organizational providers, consistent with the terms of the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request approved by HCFA in November 2000. Organizational provider defines entities that have historically participated in the Medi-Cal program as Short-Doyle/Medi-Cal providers on a cost reimbursement or negotiated rate basis involving submission of annual cost reports. These requirements will continue under this Chapter (sections 1830.105 and 1840.105). The definition also clarifies that the MHP considered an organizational provider when the MHP itself is providing services through its staff. Individual provider and group provider define providers that have historically participated in the Medi-Cal program on the basis of fee-for-service rates established by the State with no requirement for annual cost reports and that, under this Chapter, are not required to submit cost reports to the Department (Section 1840.105). These providers, absent a contract with the MHP, will be paid at the regular fee-for-service Medi-Cal rate applicable to the service provided (Section 1830.105).

This definition does not in and of itself limit the ways in which providers may provide services under this Chapter. A single provider may meet the definition of a group provider or the definition of organizational provider depending on the terms of the contract between the MHP and the provider or, absent a contract, on the way in which an individual service was delivered. Providers who deliver services as staff or contractors of an organizational provider are not precluded from also delivering services as an individual or group provider solely based on the definitions in this Article.

Section 1810.231.1. Physical Health Care or Physical Health Care Based Treatment.

Specific Purpose: Section 1810.231.1 defines a type of health care that is not covered by the MHPs.

Rationale for Necessity: This definition is necessary to provide a term to describe health care, other than specialty mental health care, so that that clear distinctions may be made between services covered by MHP and not covered by MHPs.

Section 1810.232. Plan Development.

Specific Purpose: Section 1810.232 defines a type of service activity that may be provided as a component of specific specialty mental health services as described under the definition of the services.

Rationale for Necessity: This definition is necessary to provide a clearer description of the specialty mental health services covered by the MHPs. Since this service activity is a component of many of the specialty mental health services, a separate definition prevents the unnecessary duplication that might otherwise be required in the individual service definitions.

Section 1810.233. Point of Authorization.

Specific Purpose: Section 1810.233 identifies the function within an MHP that may be established to approve or disapprove a request from a provider for MHP payment authorization.

Rationale for Necessity: This regulation is necessary to provide a single term for use in regulations dealing with the MHP payment authorization process to describe the components of the function within the MHP that may and, in emergency situations, is required to be available to perform MHP payment authorizations. The point of authorization is defined as available twenty-four hours a day, seven days a week. This is particularly critical for emergency admissions when notification of an MHP's Point of Authorization must generally occur within 24 hours of admission (Section 1820.225).

1810.234. Prior Authorization.

Specific Purpose: Section 1810.234 defines the payment authorization given by an MHP to a provider prior to the provision of specialty mental health services.

Rationale for Necessity: This definition is necessary to provide a single term for use in regulations for the prior payment authorization of specialty mental health services by MHPs. This regulation is also necessary because it allows the MHP to authorize payment for medically necessary services prior to the provision of the services.

1810.235. Provider.

Specific Purpose: Section 1810.235 identifies the types of persons and entities that are included when the term provider is used in this Chapter.

Rationale for Necessity: This definition is necessary to provide a single term for use in this Chapter when a requirement covers all individuals and entities that have the legal ability to provide specialty mental health services under this Chapter. Individuals and entities most likely to be providers are listed in the definition. An exhaustive list is not provided because the specific individuals and entities eligible to be providers may vary on a case-by-case basis. When only specific types of providers are meant, the regulations identify the specific types included or excluded. The definition also clarifies that the MHP is also a provider when the MHP itself is providing services through its staff.

Section 1810.236. Psychiatric Health Facility.

Specific Purpose: Section 1810.236 identifies a type of provider under this Chapter.

Rationale for Necessity: This definition is necessary to distinguish this type of provider from others for the purpose of establishing requirements specifically applicable to psychiatric health facilities. The definition also clarifies when facilities licensed as psychiatric health facilities will be included under the definition of hospital.

Section 1810.237. Psychiatric Health Facility Services.

Specific Purpose: Section 1810.237 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of the specialty mental health services covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definitions in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries who are not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity by substituting terms specific to this Chapter for the more general terms "non-hospital" and "acute care" used in Title 22, Section 51341.

Section 1810.237.1. Psychiatric Inpatient Hospital Professional Services.

Specific Purpose: Section 1810.237.1 defines a type of specialty mental health service covered by MHPs.

Rationale for Necessity: This definition is necessary to distinguish specialty mental health services provided to beneficiaries while they are hospitalized from similar services provided to beneficiaries on an outpatient basis or when the beneficiary is an inpatient in a facility other than a hospital. The distinction is necessary because different medical necessity criteria apply to inpatient professional services delivered in a hospital and those delivered in other inpatient settings, such as nursing facilities and because the conditions of the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request, approved by HCFA in November 2000, prohibit these services from being subject to prior authorization in an emergency. Although physicians and psychologists are generally the only licensed mental health professionals with hospital admitting privileges, it is the Department's understanding that there are some situations in which other licensed mental health professionals may also have these privileges; therefore, the definition accommodates these situations.

Section 1810.238. Psychiatric Inpatient Hospital Services.

Specific Purpose: Section 1810.238 defines a type of specialty mental health service covered by MHPs.

Rationale for Necessity: This regulation is necessary to provide a single term when these regulations apply equally to acute psychiatric inpatient services and administrative day services, both of which have been separately defined.

Section 1810.239. Psychiatric Nursing Facility Services:

Specific Purpose: Section 1810.239 defines a type of specialty mental health service that may be covered by MHPs.

Rationale for Necessity: This definition is necessary to provide a specific description of the specialty mental health services that may be covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of rate setting and provider payment and authorization procedures.

Section 1810.240. Psychiatrist Services:

Specific Purpose: Section 1810.240 defines a type of specialty mental health service covered by MHPs.

Rationale for Necessity: This regulation is necessary to establish a term that can separately identify specialty mental health services provided by individual or group providers who are physicians. Separately identifying this type of service in terms of the physician's psychiatric specialty as self-identified to the Medi-Cal program provides a basis for MHPs to identify whether a service provided by a non-contract physician in an

emergency is a specialty mental health service covered by the MHP or an excluded service. The separate identification also facilitates claiming FFP as described in Subchapter 4.

Section 1810.241. Psychologist Services:

Specific Purpose: Section 1810.241 defines a type of specialty mental health service covered by MHPs.

Rationale for Necessity: This regulation is necessary to establish a term that can separately identify specialty mental health services provided by individual or group providers who are psychologists. Separately identifying this type of service facilitates claiming FFP as described in Subchapter 4.

Section 1810.242. Receipt or Date of Receipt:

Specific Purpose: Section 1810.242 defines a standard for establishing when documents are received that will be applicable throughout this Chapter.

Rationale for Necessity: This definition is necessary in order that the MHPs and providers referenced in these regulations have a clear understanding of timelines for various documents and responses encompassed by these regulations.

Section 1810.243. Rehabilitation:

Specific Purpose: Section 1810.243 defines a type of service activity that may be provided as a component of specific specialty mental health services as described under the definition of the services.

Rationale for Necessity: This definition is necessary to provide a clearer description of the specialty mental health services covered by the MHPs. Since this service activity is a component of many of the specialty mental health services, a separate definition prevents the unnecessary duplication that might otherwise be required in the individual service definitions. The definition of the service activity provides representative examples of the types of activities included under the particular service activity. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis.

Section 1810.243.1. Rehabilitative Mental Health Services.

Specific Purpose: Section 1810.243.1 defines a category of specialty mental health services.

Rationale for Necessity: This regulation is necessary to differentiate the term Rehabilitation, a service activity, from Rehabilitative Mental Health Services, which is a general category of services.

Section 1810.243.5. Risk Reinsurance.

Specific Purpose: Section 1810.243.1 clarifies the meaning of a specific kind of expenditure allowable under the Small County Reserve.

Rationale for Necessity: This regulation is necessary because the meaning of the term "risk reinsurance" is not specified in AB 757 (Chapter 633, Statutes of 1994), which enacted sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code. Clarification is critical since the purchase of risk reinsurance, as defined, is an allowed expenditure of the Small County Reserve. The term "reinsurance" is a common industry term for this type of coverage.

Section 1810.244. Routine Hospital Services.

Specific Purpose: Section 1810.244 clarifies what is included in routine hospital services provided as part of all psychiatric inpatient hospital services covered by MHPs.

Rationale for Necessity: This Section is necessary to establish a definition of what is included in psychiatric inpatient hospital services rates that is applicable statewide. Psychiatric inpatient hospital services rates negotiated by MHPs under these regulations may be applicable to other MHPs using the same hospital. Negotiated rates also form the basis of the rates established by the Department for non-contract hospitals. The routine hospital services included have a substantial impact on total cost of hospitalization and must be consistent statewide.

Section 1810.245. Service Activities.

Specific Purpose: Section 1810.245 defines the components of specific specialty mental health services as described under the definitions of the individual services.

Rationale for Necessity: This definition is necessary to provide a clearer description of the specialty mental health services covered by the MHPs. Since service activities are components of many of the specialty mental health services, a separate definition prevents the unnecessary duplication that might otherwise be required in the individual service definitions. The definition of service activity lists as examples those service activities that are specifically defined in this Article. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis.

Section 1810.246. Short-Doyle/Medi-Cal Hospital.

Specific Purpose: Section 1810.246 defines a specific type of hospital covered by this Chapter.

Rationale for Necessity: This regulation is necessary to distinguish the difference in claims processing and payment procedures between Short-Doyle/Medi-Cal hospitals and Fee-for-Service/Medi-Cal Hospitals (see the statement of reasons for Section 1810.217).

Section 1810.246.1. Significant Support Person.

Specific Purpose: Section 1810.246.1 identifies persons who may play a significant role in the treatment of a beneficiary receiving specialty mental health services under this Chapter.

Rationale for Necessity: This regulation is necessary to provide a single term for use in these regulations when one or more individuals from this fairly extensive list of people are meant. The primary use is to identify reimbursable services for the purpose of claiming FFP under Subchapter 4; however, the term is also used to describe these individuals as self-identified (rather than identified by the beneficiary or the person providing service to the beneficiary) as individuals who should be included in specific planning and oversight functions included in this Chapter.

Section 1810.246.2. Small County.

Specific Purpose: Section 1810.246.2 defines a small county for the purpose of this Chapter.

Rationale for Necessity: This regulation is necessary to provide a clear definition of this term for use in this Chapter. Section 5778(j) of the Welfare and Institutions Code sets the population of a small county at 200,000, but does not identify the database that will establish the number. The Department established the 1990 census as the source for determining county population because census data are widely accepted and available. The Department determined that the 2000 census would not be used because the 1990 census more clearly reflects the fiscal risk factors affecting smaller counties that existed at the time the enabling legislation established 200,000 as the critical population level for small counties.

Section 1810.246.3. Small County Reserve.

Specific Purpose: Section 1810.246.3 defines the self-insurance mechanism available for small counties under this Chapter.

Rationale for Necessity: This regulation is necessary to avoid duplicative cross referencing of Section 1810.341 when the term “small county reserve” is used in other regulations in this Chapter.

Section 1810.247. Specialty Mental Health Services.

Specific Purpose: Section 1810.247 lists those services that are specialty mental health services covered by MHPs under this Chapter.

Rationale for Necessity: This regulation is necessary to provide a single term for use in this Chapter when a requirement covers all of the individual services included in this definition. When only specific types of services are meant, the regulations identify the specific types included or excluded. Each of the services listed has been separately defined.

Section 1810.248. Submit or Date of Submission.

Specific Purpose: Section 1810.248 defines a standard for establishing when documents have been submitted that will be applicable throughout this Chapter.

Rationale for Necessity: This definition is necessary in order that the MHPs and providers referenced in these regulations have a clear understanding of timelines for various documents and responses encompassed by these regulations.

Section 1810.249. Targeted Case Management.

Specific Purpose: Section 1810.249 defines a type of specialty mental health service that will be covered by the MHP.

Rationale for Necessity: This definition is necessary to provide a specific description of the specialty mental health services covered by the MHPs and to distinguish among the specialty mental health services covered by the MHP for the purpose of claiming FFP as described in Subchapter 4, particularly in terms of the maximum allowable rates established in Section 1840.105. The definition is based on the definition of case management brokerage in Title 22, Section 51341, which describes Short-Doyle/Medi-Cal Mental Health Program Services available to beneficiaries not covered by this Chapter. Variations from the definitions in Title 22, Section 51341 have been made to improve clarity. The definition is made consistent with the structure of other service definitions in this Chapter by using defined service activities to describe the content of the service in more detail. The list of service activities includes those that are likely to be components of the service. An exhaustive list is not provided because specific service activities may vary on a case-by-case basis. The reference in Title 22, Section 51341 to the program staff because it may be interpreted as an unintended limit on the persons who may provide targeted case management services.

Section 1810.250. Therapy.

Specific Purpose: Section 1810.250 defines a type of service activity that may be provided as a component of specific specialty mental health services as described under the definition of the services.

Rationale for Necessity: This definition is necessary to provide a clearer description of the specialty mental health services covered by the MHPs. Since this service activity is a component of many of the specialty mental health services, a separate definition prevents the unnecessary duplication that might otherwise be required in the individual service definitions.

Section 1810.251. Third Party Liability.

Specific Purpose: Section 1810.251 defines this term for use in this Chapter.

Rationale for Necessity: This regulation is necessary to define a term with a generally accepted meaning in the health care industry to be specifically applicable to the situations governed by this Chapter.

Section 1810.252. Traditional Hospital.

Specific Purpose: Section 1810.252 defines a specific type of hospital.

Rationale for Necessity: This Section is necessary because these regulations establish contract requirements for MHPs for different classes of hospitals based upon the hospital's history of providing of services to Medi-Cal beneficiaries and other low-income individuals. One of these classes of hospitals is the traditional hospital. The level of service to Medi-Cal beneficiaries that qualifies a hospital as a traditional hospital was set at the greater of five percent or $20,000 of the MHP's total Fee-for-Service/Medi-Cal hospital expenditures to ensure participation of hospitals that have regularly served beneficiaries of an MHP without requiring the MHP to administer contracts with hospitals providing few services.

Section 1810.253. Urgent Condition.

Specific Purpose: Section 1810.253 defines the clinical conditions that constitute an urgent condition under this Chapter.

Rationale for Necessity: This definition is necessary to provide clear direction to MHPs and providers about what constitutes an urgent condition under this Chapter.

Section 1810.253.1. Usual and Customary Charges.

Specific Purpose: Section 1810.253.1 defines a term related to provider reimbursement under this Chapter.

Rationale for Necessity: This regulation is necessary to distinguish between the charges a provider usually submits for billing and the reimbursement rates established within this Chapter. The distinction is necessary because Medi-Cal laws generally do not permit a provider to bill the Medi-Cal program at a higher rate than the rate the provider charges for other patients.

Section 1810.254. Waivered/Registered Professional.

Specific Purpose: Section 1810.254 defines a category of mental health professionals for use in this Chapter.

Rationale for Necessity: This regulation is necessary because it provides a single term for use in this Chapter when all of the individuals included in this definition are meant. Individuals included in this definition may provide specific specialty mental health services and may perform specific administrative functions.

Article 3. Administration

Section 1810.305. Designation of MHPs.

Specific Purpose: Section 1810.305 specifies the requirements of a qualifying entity that may be designated as the MHP by the Department.

Rationale for Necessity: This regulation is necessary because it puts AB 757 (Chapter 633, Statutes of 1994), which enacted sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, into operation by implementing and developing the specific components of the plan for Medi-Cal mental health managed care. This regulation requires entities that intend to be designated as MHPs to comply with these specific components. This regulation is necessary to ensure that designated MHPs meet the requirements of federal and State statutes.

Subsections (a)(1)—(4) lists the requirements for a resolution by a board of supervisors of a county that wishes to be designated as an MHP. These subsections are necessary because they ensure that the county or non-county entity that is designated as an MHP will formally commit to provide Medi-Cal authorization and payment; access to specialty mental health services; allocation of State funds as full payment; and a public planning process for formulating the Implementation Plan. These provisions are derived from the requirements of AB 757 (Chapter 633, Statutes of 1994) as expressed in sections 5775, 5777, 5778, and 14684 of the Welfare and Institutions Code.

Subsection (b)(1)—(5) is necessary because it provides a process for a qualified entity to be chosen as the MHP, if the county chooses not to assume that responsibility or fails to comply with public planning process or Implementation Plan requirements, or if the Department or the county terminates or fails to renew the contract between the MHP and the Department.

Subsection (c) is necessary to obligate an entity designated under Subsection (b) to the same duties and responsibilities that are required of a county designated under subsection (a).

Subsection (d) is necessary to allow the Department the option of utilizing a competitive procurement process for the Department's designation of an MHP, and allows the Department to incorporate the requirements of Subsection (a) and Section 1810.310, which covers the Implementation Plan, into the procurement process at the appropriate stage.

Section 1810.310. Implementation Plan.

Specific Purpose: Section 1810.310 describes the required contents and deadlines for initial submission and changes to the Implementation Plan for specialty mental health services by the MHP that each applicant entity must submit in order to be considered as an MHP applicant.

Rationale for Necessity: This regulation sets forth the requirement for submission of an Implementation Plan to the Department for review within a timeframe established by the Department.

Subsections (a)(1)-(11) are necessary because the specific requirements of the Implementation Plan must be clearly identified to potential MHPs, beneficiaries, and other interested parties. These subsections require all applicant entities to submit the same information to the Department for consideration in order to attain consistency, require the entities to offer an appropriate range of specialty mental health services adequate for the anticipated number of beneficiaries that will be served by the MHP, and maintain a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of beneficiaries that will be served by the MHP. The MHP makes assessments to estimate the anticipated number of beneficiaries to be served. The established timeframe of no more than 180 days and no less than 90 calendar days prior to the MHP's operation start date is necessary to provide for the Department's review and for adequate time to modify original Implementation Plans.

Subsection (b) is necessary because it provides a review and approval process by the Department for each Implementation Plan. The timeframe of 60 days allows the Department a reasonable time to evaluate the Implementation Plans and it allows the MHPs a sufficient period of time to provide additional information, if needed.

Subsection (c) is necessary because it provides a process for modification of Implementation Plans. The Subsection, consistent with Title 42, CFR, Section 438.207, includes the requirement that MHPs provide documentation to the Department when there is a significant change in the MHP's network. A significant change is defined as a change that would require a change in services or providers by 25 percent or more of the beneficiaries who are receiving services from the MHP or a reduction of an average of 25 percent or more in provider rates for providers of outpatient mental health services that paid on a fee-for-service basis. Through a process that involved a consensus between the Department and stakeholders, it was agreed that defining a significant change at the 25 percent level will ensure that the Department is informed when changes in the MHP's operation are at a level that is more likely to impair beneficiary access to services and require review by the Department without unduly burdening the MHPs with additional reporting requirements. Nothing in this subsection relieves MHPs of their obligations to notify individual beneficiaries when the MHP makes changes to the beneficiary's providers or services. The 30-day time frame as contained in (c)(4) allows adequate time for review by the Department and proper notification of the MHP.

Section 1810.315. Contracts between the Department and the MHP.

Specific Purpose: Section 1810.315 sets forth the requirement for a written agreement between the Department and the MHP that describes the terms and conditions for providing specialty mental health services to Medi-Cal beneficiaries.

Rationale for Necessity: This regulation is necessary because it sets forth the requirements of AB 757 (Chapter 633, Statutes of 1994) as expressed Section 5775(c)

of the Welfare and Institutions Code for a formal mechanism to ensure that MHPs provide beneficiaries with the specialty mental health services covered by this Chapter.

This Section (a) is necessary to clarify that the entity designated as the MHP under Section 1810.305 that submits an Implementation Plan under Section 1810.310 that is approved by the Department is obligated to enter into a contract with the Department as the MHP and is not entitled to funds from the Department until the contract is executed.

Section 1810.317. Contract Term.

Specific Purpose: This Section sets forth conditions related to the term of the contract.

Rationale for Necessity: This Section is necessary to establish conditions related to the term of the contract between the Department and the MHP. The expiration date of June 30 was chosen in order to be consistent with the contract period for the allocation of State funds to the MHPs, which will be the beginning and ending dates of the State fiscal year.

Section 1810.319. Contract Amendment.

Specific Purpose: This Section sets forth the basis for amendment of the contract.

Rationale for Necessity: This Section is necessary to provide clear authority in regulation to amend the contract by mutual written agreement.

Section 1810.321. Contract Renewal.

Specific Purpose: Section 1810.230 specifies the conditions under which an MHP contract will be renewed.

Rationale for Necessity: This regulation is necessary because it provides for renewal of an MHP's contract with the Department, as provided AB 757 (Chapter 633, Statutes of 1994) in Section 5777(b) of the Welfare and Institutions Code and sets timeframes for notice of decisions not to renew the contract by the MHP or the Department.

Subsection (a) describes the Department's authority to decide to renew or not to renew an MHP's contract.

Subsection (b) is necessary to provide the MHP reasonable time to provide notice of non-renewal in order to provide for continued treatment of beneficiaries of the MHP. The 180-day timeframe is established by AB 757 (Chapter 633, Statutes of 1994) in Section 5777(e) of the Welfare and Institutions Code and allows the Department a reasonable amount of time to designate another entity to be the MHP for that county.

Subsection (c) is necessary to establish a timeframe for notice when the Department makes the decision not to renew an MHP contract. Although AB 757 (Chapter 633, Statutes of 1994), which enacted sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, did not establish timeframes, the Department has

determined that, absent compliance problems on the part of the MHP, the notice should be the same as the notice required of the MHP in Subsection (b). If compliance problems are identified, a 90-day notice is provided, consistent with the timeframe for notice of contract termination in Section 1810.325(d).

Section 1810.323. Contract Termination.

Specific Purpose: Section 1810.325 sets forth the procedures and conditions by which either the Department or the MHP may terminate its contract with the other.

Rationale for Necessity: This regulation is necessary because it provides for termination of an MHP's contract with the Department consistent with the requirements of AB 757 (Chapter 633, Statutes of 1994) as described in Section 5777(d) and (e) of the Welfare and Institutions Code.

Subsection (a) is necessary because it provides the MHP with authority in regulation to terminate its contract with the Department. The notification requirement of at least 180 days prior to the effective date of termination was selected in accordance with AB 757 (Chapter 633, Statutes of 1994) in Section 5777(d) of the Welfare and Institutions Code. The 180-day timeframe also allows the Department a reasonable amount of time to arrange for contracting with other qualifying entities to serve as the MHP for the affected county.

Subsection (b) is necessary to establish authority in regulation for the Department to terminate an MHP contract without notice if the reason for the termination is the immediate health and safety of the beneficiaries served by the MHP.

Subsection (c) is necessary in order to ensure compliance with the federal requirements of the Medicaid program. When the Secretary, Health and Human Services determines that the program does not meet federal requirements, the federal matching funds available under the Medi-Cal program, referred to as federal financial participation (FFP), for expenditures for specialty mental health services may be discontinued with short notice. The notification requirement of at least 60 days was selected to provide time for reasonable notice to beneficiaries and the MHP, while taking into account the loss of funding available to the MHP for services they are obligated to provide.

Subsection (d) is necessary because it provides the Department with authority in regulation to terminate the MHP contract for noncompliance. The notification requirement of at least 90 days was selected because it provides the MHP with a sufficient amount of time to ameliorate the situation or request an administrative hearing.

Subsection (e) is necessary because it provides the Department with authority in regulation to terminate the MHP contract for reasons not otherwise specified in regulation. The notification requirement of at least 180 days prior to the effective date of termination was selected in accordance with AB 757 (Chapter 633, Statutes of 1994) in Section 5777(e) of the Welfare and Institutions Code. The 180-day timeframe also

allows the Department a reasonable amount of time to arrange for contracting with other qualifying entities to serve as the MHP for the affected county.

Subsection (f) is necessary to allow termination of an MHP's contract with the Department if the Department determines that continuation of the contract is not in the best interests of the State.

Subsection (g) is necessary because it provides for general notification regarding the termination of the MHP contract to all affected parties. This Subsection is also in accordance with AB 757 (Chapter 633, Statutes of 1994) in Section 5777(d) of the Welfare and Institutions Code.

Subsection (h) is necessary because these are the minimum components of a notice of termination that will allow the MHP to decide whether to appeal the Department's action.

Subsection (i) is necessary to protect the integrity of State funds, which AB 757 (Chapter 633, Statutes of 1994), in Section 5778 (p) of the Welfare and Institutions Code, requires to be spent only for the provisions of mental health services, in the event an agreement with an MHP must be terminated, regardless of the reason for the termination

Section 1810.325. Appeal of Contract Termination.

Specific Purpose: Section 1810.325 sets forth the procedural steps and timelines for an MHP to appeal a contract termination.

Rationale for Necessity: This Section is necessary to provide the procedural steps and timelines for an MHP in appealing the Department's notice of termination, either to the Department or to the Office of Administrative Hearings, as provided in AB 757 (Chapter 633, Statutes of 1994) in Section 5777(d) of the Welfare and Institutions Code. The timelines allow for a decision in most cases prior to the effective date of the termination contained in the notice of termination.

Subsection (a) sets forth the procedures and timelines whereby an MHP may appeal a termination of its MHP contract by the Department.

Subsection (b) sets forth the procedures and timelines whereby an MHP may request a public hearing by the Office of Administrative Hearings to allow the Department to show cause for the termination.

Subsection (c) sets forth procedures and timelines whereby the Office of Administrative Hearings will communicate its findings to the MHP and the Department. The Subsection explains that the Department has specific timelines to make a final decision on the appeal after receiving recommendations from the Office of Administrative Hearings. The Subsection explains that, if the Department decides not to terminate the contract, the Department may take other actions against the MHP under Section 1810.380(b). The Subsection explains that the Department must suspend a contract

termination pending the outcome of an appeal unless the termination was based on an immediate threat to the health and safety of beneficiaries.

Section 1810.330. Allocation of State Funds to MHPs.

Specific Purpose: Section 1810.330 sets forth the Department's responsibility to determine the methodology for allocating State funds to the MHPs annually.

Rationale for Necessity: This regulation is necessary to explain that the method for allocating State funds to the MHPs, including the Small County Reserve Allocation, will be determined annually by the Department in consultation with a statewide organization representing counties, currently the California Mental Health Directors Association. This is consistent with Section 5778 (k) of the Welfare and Institutions Code, which specifically provides that the allocation will be determined by the Department and the statewide organization representing counties. The regulation provides for an annual determination because the Department's experience with the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation program, which was implemented in January 1995, indicates that the ability to reconsider and revise the methodology based on new information must occur on a regular basis in conjunction with changes in the overall Medi-Cal program, which occur annually as a part of the State's annual budget process.

This regulation also provides authority for the following component of the allocation process that is not specifically addressed in statute. The allocation methodology must accommodate providing MHPs with funds to cover those few Medi-Cal covered specialty mental health services that are not eligible for FFP, including specific services that may legally be provided to minors without parental consent and specialty mental health services provided to most beneficiaries under the age of 65 who reside in institutions for mental disease. State funding for specialty mental health services normally reflects the percentage (currently 50 percent) of the total dollars historically spent on services not covered by FFP. The MHP collects the total dollars by claiming FFP for the specialty mental health services it provides. When FFP is not available for a service, the State funding level must be at 100 percent. The services covered by the MHP and not eligible for FFP are professional services provided to beneficiaries who are inpatients in institutions for mental disease and beneficiaries who are eligible for Medi-Cal based on the need for minor consent services.

Section 1810.335. Re-negotiation of the Allocation of State Funds to an MHP.

Specific Purpose: Section 1810.335 provides for a re-negotiation of allocated State funds paid to the MHP for the fiscal year when there have been changes in the obligations of the MHP as a result of changes in the interpretation or implementation of federal or State law or regulation that increases or decreases the cost of providing services under the contract.

Rationale for Necessity: This regulation is necessary to provide a complete picture of the process for allocation of State funds to MHPs in this Chapter. The regulation describes the option of both the Department and the MHP to renegotiate the amount allocated under Section 1810.335 in accordance with Section 5777(c) of the Welfare

and Institutions Code. The option for re-negotiation is necessary to protect the MHP against unexpected costs and the Department against distributing excess funds.

1810.341. Small County Reserve Allocation.

Specific Purpose: Section 1810.341 specifies the regulatory requirements governing the Small County Reserve, which provides a level of protection for MHPs in small counties against the cost of psychiatric inpatient hospital services and other specialty mental health services in excess of their individual allocations of State matching funds.

Rationale for Necessity: This Section provides the methodology for release of Small County Reserve funds to small counties, as defined in these regulations, for reimbursement of the cost of psychiatric inpatient hospital services and other specialty mental health services. The Reserve was established in recognition that, because of the small number of beneficiaries covered by each MHP, the annual costs of serving beneficiaries could easily exceed the State matching funds available to the MHP.

Subsection (a) is necessary to explain that small county MHPs are responsible to establish the Small County Reserve with the funds allocated by the Department.

Subsections (b)(1)-(4) are necessary to specify the allowable expenditures of Small County Reserve funds.

Subsection (c) is necessary to describe the disposition of interest earned on reserve funds.

Subsection (d) is necessary to clarify that the Department is not financially responsible for costs that exceed the balance in the Small County Reserve; rather it is the MHPs in small counties and the Utilization Control and Operations Committee that are legally obligated. This Section also specifies the disposition of unexpended funds and requires annual reporting of the Small County Reserve balance.

Subsections (e) and (f)(1)-(5) are necessary to establish the process for appointing members of the Utilization Control and Operations Committee, which will administer the reserve; and to specify the specific duties of the Committee.

Section 1810.345. Scope of Covered Specialty Mental Health Services.

Specific Purpose: Section 1810.345 sets forth the extent of the MHPs' responsibilities for specialty mental health services to the beneficiaries of the MHP.

Rationale for Necessity: This regulation is necessary to clarify for beneficiaries, providers, the MHPs, and other interested parties when a specialty mental health service is covered by an MHP and when it is not. This regulation establishes the statewide minimum required scope of benefits to be provided to beneficiaries by MHPs, consistent with State and federal requirements and in accordance with AB 757 (Chapter 633, Statutes of 1994) in Section 5777(a)(3) of the Welfare and Institutions Code. This

regulation creates a necessary link among regulations governing access and the provision of services.

Subsection (a) establishes that the medical necessity criteria applicable to psychiatric inpatient hospital services and specialty mental health services, other than psychiatric inpatient hospital services, as identified by cross-references to the specific regulations, must be met before an MHP is required to cover a specialty mental health service. The regulation provides an essential exception to this requirement to clarify the MHPs' responsibility to assess beneficiaries for whom medical necessity has not yet been established.

Subsection (a)(1) and (2) explains that MHPs are not responsible to provide specialty mental health services to beneficiaries unless the beneficiary is eligible for the service under the Medi-Cal program. Some Medi-Cal beneficiaries will not be eligible for all specialty mental health services covered by the MHP. For example, beneficiaries who are eligible for emergency services only under the Medi-Cal program will be eligible to receive only the specialty mental health services required to treat an emergency psychiatric condition. Some Medi-Cal beneficiaries will not be eligible for any specialty mental health services until their share of cost obligation is fulfilled.

Subsection (b) is necessary because it establishes that, once the MHP determines that specialty mental health services are medically necessary, the MHP is not generally required by this Chapter to provide any specific type of specialty mental health service to the beneficiary, if the MHP provides services that meet the needs of the beneficiary. For example, if, in the opinion of the MHP, either adult residential treatment services or a combination of mental health services and case management in the community would provide appropriate treatment of the beneficiary's conditions, the MHP may choose the service to be provided. Also, if, in the opinion of the MHP, group therapy provided as a mental health service would provide equal therapeutic benefit to its beneficiaries as day treatment intensive and can be managed more effectively, the MHP may provide this mental health service, rather than day treatment intensive. The appropriateness of individual decisions by the MHP remain subject to both the beneficiary problem resolution process and the fair hearing process. The regulation also mentions that there are exceptions to the MHP's flexibility in this area based on other regulations in this Chapter. The key specialty mental health services not subject to this Section are specialty mental health services provided to beneficiaries with emergency psychiatric conditions (psychiatric inpatient hospital services, psychiatric inpatient hospital professional services and psychiatric health facility services).

Subsection (c) is necessary because it explains that all specialty mental health services provided by an MHP to a beneficiary must be compliant with the stated goals of rehabilitative mental health services as required by federal law and described in the Medi-Cal State Plan.

Subsection (d) is necessary to provide for the exclusion of psychiatric nursing facility services from coverage by the MHPs. The Department has identified it may be necessary to delay inclusion of these services in MHP contracts indefinitely. The State's strategy for meeting the long term care needs for California residents, including

individuals who are mentally ill is currently being reviewed and evaluated on a statewide basis pursuant to Executive Order No. S-18-04.

Section 1810.350. Scope of Covered Psychiatric Inpatient Hospital Services.

Specific Purpose: Section 1810.350 describes the components included in psychiatric inpatient hospital services covered by the MHP available to Medi-Cal beneficiaries. This regulation also specifies the MHP's responsibility for payment authorization of these services and for payment authorization of administrative day services for Medicare eligible beneficiaries.

Rationale for Necessity: This regulation is necessary to describe a range of services that must be included in the MHPs' reimbursement for psychiatric inpatient hospital services.

Subsection (a) is necessary to ensure that MHPs will be accountable for payment authorization of psychiatric inpatient hospital services for Medi-Cal beneficiaries.

Subsections (b) and (c) are necessary to differentiate the psychiatric inpatient hospital services covered by the per diem rate in a Fee-for-Service/Medi-Cal hospital, which does not include psychiatric inpatient hospital professional services; from those services covered in a Short-Doyle/Medi-Cal hospital, which does include psychiatric inpatient hospital professional services.

Subsection (d) is necessary to ensure that MHPs will be accountable for payment authorization of administrative day services for Medicare eligible beneficiaries, even though the MHP will not have authorized the initial admission for acute psychiatric inpatient hospital services.

Section 1810.355. Excluded Services.

Specific Purpose: Section 1810.355 identifies the specific kinds of Medi-Cal services and certain specialty mental health services that are excluded from coverage by MHPs under this Chapter.

Rationale for Necessity: This regulation is necessary to clarify that not all services that might be perceived as specialty mental health services are the responsibility of the MHP and to prevent potential misunderstandings among beneficiaries, providers and MHPs regarding coverage of services.

Subsection (a) excludes all Medi-Cal services that are not the specialty mental health services as defined in this Chapter. More detail is provided for the excluded services in this category that have the greatest likelihood to cause misunderstandings. Prescribed drugs and laboratory and radiology services are identified here because of current confusion surrounding these services for beneficiaries who are also members of Medi-Cal managed care plans. Medical transportation services are identified to make it clear that although these services are not covered by the MHPs, the MHPs must pay for these services when there is no medical reason for the transportation services.

Physician services that are not psychiatrist services are identified to make it clear that the services of primary care physicians and specialists such as neurologists are not covered by the MHPs. Personal care services are identified because there is potential for confusion between therapeutic services covered by the MHPs that may provide assistance in restoring and maintaining a beneficiary's daily living skills and personal care services, which involve performing activities of daily living for the beneficiaries.

Subsections (b) and (d)—(f) identify services that are specialty mental health services, but are not covered by the MHP because the Department has determined that these services can be more effectively managed outside the MHP or, in the case of Medicare or Medi-Cal managed care plan covered services, that inclusion would result in inappropriate payments under the Medi-Cal program.

Subsection (c) explains that specialty mental health services provided in a State hospital operated by the Department of Mental Health or developmental center operated by the Department of Developmental Services are excluded from coverage by the MHP. Generally, services in these state-operated facilities are not covered by the Medi-Cal program, but are funded through State general fund allocations to each county, and State facility services are purchased by the counties from the State. When they are covered by the Medi-Cal program, however, the MHPs are not responsible for the services.

Subsection (g) lists specialty mental health services that are components of Medi-Cal services that include many service components billed to the Medi-Cal program as a single service. Inclusion of these services in the responsibilities of the MHP would result in inappropriate payments under the Medi-Cal program. Subsection (g) also lists Medi-Cal services that are provided by special programs (e.g., the California Children's Services Program, the Genetically Handicapped Persons Program and Local Education Agency Programs).

Section 1810.360. Notification of Beneficiaries.

Specific Purpose: Section 1810.360 specifies the responsibilities of both the Department and the MHPs in notifying all beneficiaries, including new beneficiaries, about the MHP's operation, available services, provider list, access to services, and problem resolution processes, including the right to a fair.

Rationale for Necessity: This regulation is necessary to ensure that beneficiaries are provided with information they need to obtain Medi-Cal specialty mental health services from an MHP and to deal with any problems they may have with the MHP.

Subsection (a) is necessary because it lists the information the Department will provide to all beneficiaries in a county.

Subsection (b) is necessary because it ensures that the Department will provide Information to beneficiaries enrolled in Medi-Cal subsequent to the general county notice.

Subsection (c) is necessary to conform to the requirements of Title 42, CFR, Section 438.10(f)(6) and (g) applicable to the Medi-Cal Specialty Mental Health Services Consolidation program. The Department has determined that the Department, rather than the MHPs, will be responsible to provide an annual written notice to all Medi-Cal beneficiaries and a notice to all new Medi-Cal beneficiaries, because the Department has better access to information on the Medi-Cal population as a whole. The Department has determined that the MHPs will be responsible to provide a booklet and provider list to beneficiaries upon request and when the beneficiary first receives specialty mental health services, because the MHPs have better access to beneficiaries at the point in time that the beneficiaries contact the MHP.

Subsection (d) lists the four necessary informative components of the beneficiary booklet.

Subsection (e) is necessary to conform to the requirement of Title 42, CFR, Section 438.10(f)(4) that beneficiaries receive a 30-day written notice when there is a significant change in the information in the booklet and provider list. A significant change is defined as a change in the scope of services covered by the MHP. The Department determined that defining a significant change as a change in the scope of covered services will ensure that the beneficiaries are informed when there is a change that clearly affects all beneficiaries without undue administrative costs to the MHPs. Nothing in this subsection relieves MHPs of their obligations to notify individual beneficiaries when the MHP makes changes to the beneficiary's providers or services.

Section 1810.365. Beneficiary Billing.

Specific Purpose: Section 1810.365 prohibits the MHP and its providers from billing beneficiaries except in specific situations.

Rationale for Necessity: This regulation is necessary to clarify that an MHP and its providers are customarily not allowed to bill beneficiaries for specialty mental health services or other related administrative services, such as billing for missed appointments or for transferring medical records to a new provider.

Subsection (a) is necessary because it provides the MHP with authority in regulation to collect reimbursement directly from the beneficiary, when the beneficiary has other health care coverage, a share of cost, or a co-payment pursuant to the cited laws and regulations applicable to the regular Medi-Cal program.

Subsection (b) is necessary to establish the providers' authority to bill the beneficiary as a private pay patient when the beneficiary willfully refuses to provide other current health insurance coverage billing information.

Section 1810.370. MOUs with Medi-Cal Managed Care Plans.

Specific Purpose: Section 1810.370 requires that there be a written MOU between MHPs and Medi-Cal managed care plans (MCPs) and specifies the minimum required

elements of the MOU and provides limited circumstances in which the requirement for an MOU may be waived.

Rationale for Necessity: This regulation is necessary to provide for an agreement between MHPs and MCPs on how interrelated and overlapping areas of responsibilities will be handled.

Subsections (a)(1)-(5) are necessary to coordinate care between the MHPs and MCPs and to provide beneficiaries with continuity of care and adequate case management. MOUs meet the requirement of AB 757 (Chapter 633, Statutes of 1994) as expressed in sections 5777(d)(2), 14681 and 14683 of the Welfare and Institutions Code, that the Department in consultation with the State Department of Health Services, ensure that MHPs and MCPs include a process for screening, referral, and coordination of necessary health and mental health services. Subsection (a)(4)(A), paragraphs 3 and 4 also comply with the requirements of section 5777.5 of the Welfare and Institutions Code that the MOUs include specific processes to address the MHP's responsibilities to facilitate a beneficiary's ability to obtain medications prescribed by the MHP's providers from the MCPs.

Subsection (b) is necessary to cover situations in which, despite its good faith efforts, the MHP cannot reach agreement with the MCP. Without this provision, failure to enter into an MOU would be subject to civil penalties or other corrective action by the Department.

Section 1810.375. MHP Reporting.

Specific Purpose: Section 1810.375 establishes the types of reports and the reporting frequency that MHPs must provide to the Department.

Rationale for Necessity: This regulation is necessary allow the Department to fulfill its monitoring and evaluating responsibilities in a cost-effective manner.

Subsection (a) is necessary to provide the Department a tracking mechanism for monitoring beneficiaries' concerns regarding services. The submittal date of October 1 was selected to allow the MHP adequate time to prepare the report.

Subsection (b) is necessary to enable the Department to fulfill its responsibilities for rate setting for non-negotiated rate Fee-for-Service/Medi-Cal hospitals by requiring that MHPs shall supply the Department with a list of all hospitals with which it has a current contract. Reporting has been established as an annual requirement consistent with the annual rate setting process covered in Article 1 of Subchapter 2 and Article 1 of Subchapter 3. The October 1 due date allows reasonable time for MHPs to complete the annual negotiations.

Subsection (c) is necessary to allow the Department to provide current rates expeditiously to the fiscal intermediary in order to pay claims and to the provider so that they are aware of the rates. The Department must have all the rates within a region as negotiated by the MHPs in order to calculate non-negotiated rates by rate region as

provided by Section 1820.115 of the regulations. The timeframe of 30 calendar days prior to the beginning of the State fiscal year was selected to assure that complete data will be obtained from all the MHPs, in order to calculate the non-negotiated hospital rates by rate region before the beginning of the fiscal year.

Subsection (d) is necessary because, while AB 757 (Chapter 633, Statutes of 1994), which enacted sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, specifically requires that an MHP report the balance of its allocation on an annual basis, specific details of the process are undefined. This Section is necessary to assure that comparative data will be obtained from all MHPs. The date of December 31 was selected because it coincides with currently existing reporting requirements for the Department's Cost Reporting and Data Collection system, which documents Short-Doyle/Medi-Cal expenditures as provided in Welfare and Institutions Code, Section 5718(c). Additionally, this regulation simply states that "an organizational entity" shall administer the Small County Reserve without specifically naming an entity. This is because this entity may change as small counties decide who will take on that risk and responsibility.

Subsection (e) is necessary to clarify that the reports required here are not exhaustive, but that additional reporting requirements will not be added arbitrarily, but as a part of the contract between the MHP and the Department.

Section 1810.380. State Oversight.

Specific Purpose: Section 1810.380 describes the Department's responsibilities for oversight of MHPs. This Section also describes the actions available to the Department when an MHP is not in compliance with its obligations.

Rationale for Necessity: This regulation is necessary because AB 757 (Chapter 633, Statutes of 1994), which enacted sections 5775 through 5780 and 14680 through 14685 of the Welfare and Institutions Code, specifically transfers certain oversight responsibilities to the Department from the State Department of Health Services coincident with the transfer of funding. It is necessary to provide oversight to the MHPs to ensure quality, access, and cost efficiency.

Subsection (a) is necessary to describe the review visits the Department will make and the specific data the Department will collect and analyze in the course of performing its oversight duties. This Subsection is also necessary to describe the requirement in Title 42, CFR, Section 438.204, annual external, independent reviews of the quality outcomes and timeliness of, and access to, the services covered by the MHPs.

Subsection (b) is necessary because oversight activity requires the ability to take corrective action, if appropriate, to ensure compliance. The actions listed are consistent with Section 5775 of the Welfare and Institutions Code.

Subsection (c) is necessary to provide a clear process for notifying the MHP when it is not in compliance. This Section is also necessary because it specifies the initial procedures for taking corrective action by requiring the Department to send a notice of

noncompliance with the specified contents to the MHP describing violations, corrective action, time limits for compliance, and appeal rights.

Subsection (d) is necessary because it describes the time limits for the appeal process regarding the Notice of Noncompliance. The timeframe of 15 working days allows the MHP a reasonable time to present relevant facts and arguments. The 30-day timeframe allows adequate time for Departmental review and for granting or denying the appeal.

Subsection (e) is necessary because it explains how the Department in consultation with primary stakeholders will update the oversight program.

Section 1810.385. Civil Penalties.

Specific Purpose: Section 1810.385 sets forth how the Department shall impose civil penalties on MHPs that violate applicable laws, regulations, or contract requirements and identifies the dollar amounts of these penalties.

Rationale for Necessity: This regulation is necessary to allow the Department to exercise the necessary legal and financial leverage to enforce compliance with legal, regulatory or contractual requirements by means of fines for specific types of violations.

Subsection (b) is necessary to set forth the specific fines for various types of violations. The amounts were modeled on regulations applicable to prepaid health plans (a type of Medi-Cal managed care plan) in Title 22, CCR, Section 53350. The highest fines have been established for violations affecting beneficiaries' rights with respect to the resolution of problems with the MHP. Fines for reports or actions that must be accomplished by a specific date are set to increase each day compliance is delayed.

Subsection (c) is necessary to allow the Department to fine an MHP a second time, when it fails to comply with corrective actions by a specified deadline.

Article 4. Standards

Section 1810.405. Access Standards for Specialty Mental Health Services.

Specific Purpose: Section 1810.405 establishes standards governing the responsibilities of the MHPs to ensure that beneficiaries have appropriate access to specialty mental health services covered by the MHPs.

Rationale for Necessity: Subsection (a) is necessary because it designates the MHP of the beneficiary as the MHP responsible for providing access to specialty mental health services under provisions of this chapter.

Subsection (b)(1)-(6) is necessary because it describes the origin of referral to specialty mental health services and lists some typical referral sources. This subsection clarifies that there is not a single gatekeeper, but that referrals may come from various sources including self-referral by the beneficiary.

Subsection (c) is necessary because it establishes the basis for a beneficiary's access to treatment of urgent conditions through the MHP. It establishes the requirement for MHPs to provide 24 hour, seven day per week toll-free telephone access for authorization purposes, if the MHP requires authorization prior to a provider beginning treatment for an urgent condition. The time frame of one hour was determined to be the most reasonable time to obtain authorization for treatment of urgent conditions. The subsection further explains timeframes the MHP is required to act on the authorization request for urgent services.

Subsection (d) is necessary because it describes the requirement for MHPs to provide statewide, 24 hour, toll-free telephone service with linguistic capability in all languages spoken by the MHPs' beneficiaries for information about access to specialty mental health services, including assessments of medical necessity and urgent services, and the beneficiary problem resolution and fair hearing process.

Subsection (e) is necessary to require the MHP is to provide a second opinion to a beneficiary if an MHP or an MHP's provider determines that medical necessity criteria to receive any services from the MHP are not present. A second opinion is important in these cases because an incorrect decision on the part of the MHP may seriously impact the beneficiary's ability to obtain appropriate services elsewhere, and some beneficiaries may be reluctant to use the beneficiary problem resolution and fair hearing processes to challenge an MHP's decision. The requirement allows MHPs considerable flexibility determining who may provide second opinions and the relationship between the professional and the MHP (e.g., the professional may be an MHP employee or a professional who is an independent contractor). This flexibility allows an important additional option to beneficiaries without adding significant costs or administrative burdens to the MHPs. Psychiatric technicians and licensed vocational nurses may not provide second opinions, because these professionals would not typically be qualified to review all the issues involved in a medical necessity decision.

Subsection (f) requires a written log of initial requests for specialty mental health services by beneficiaries of the MHP or a reasonable alternative. The regulation will enable the MHP and the Department and other oversight agencies to monitor beneficiaries' access to specialty mental health services. The subsection provides for reasonable equivalents to the written log, e.g., an electronic tracking system, provided the data remains accessible to review by the Department and other oversight agencies. The regulation provides that approval for reasonable alternatives will be obtained through the Implementation Plan approval process described in Section 1810.410.

Section 1810.410. Cultural Competency and Linguistic Requirements.

Specific Purpose: Section 1810.410 explains the minimum requirements for MHPs in terms of meeting the needs of beneficiaries with primary languages other than English and developing itself as a culturally competent organization.

Rationale for Necessity: This section is necessary to establish specific responsibilities of the MHPs for serving beneficiaries' language and cultural needs. The section clarifies for the MHPs and other affected parties that these responsibilities may be

included in the terms of the contract between the MHP and the Department and the MHP's Cultural Competence Plan, for which a general outline is provided in subsection (c) in addition to requirements specifically stated in subsection (e). The section reflects the work of the Cultural Competence Task Force (now the Cultural Competence Advisory Committee), which was convened by the Department to study these issues and make recommendations to the Department and the Department's decisions based on the recommendations of the task force. A more detailed description of the Department's rationale for this section and the responsibilities of the MHPs is contained in the Department's Information Notice Number 02-03 entitled "Addendum for Implementation Plan for Phase II Consolidation of Medi-Cal Specialty Mental Health Services—Cultural Competence Plan Requirements," dated May 2, 2002. The Department expects that the contracts between the Department and the MHP will establish reasonable time frames for development of the Cultural Competence Plan and specific methods for population and organizational/provider assessments and for measurement of MHP performance under this section consistent with the discussion of these items in the Information Notice.

Section 1810.415. Coordination of Physical and Mental Health Care.

Specific Purpose: Section 1810.415 provides guidelines for coordination of services for beneficiaries between physical health care providers, including MCPs, and the MHPs.

Rationale for Necessity: This regulation is necessary because some mental health conditions are treated by primary care providers and in order to insure an efficient and cohesive understanding of physical health related issues, directives and guidelines are required to clearly define the MHPs' and physical health care providers' responsibilities.

Subsection (a) is necessary to establish the MHP's obligation to provide training and consultation to beneficiaries' primary care physicians and other health care providers, who require specialized information to treat mental health problems effectively. Although primary care physicians are generally acknowledged to be the providers to whom most people go for treatment of mental health problems, literature suggests that many primary care physicians have not received sufficient training in this area, particularly in the area of prescribing appropriate drugs and dosages. The availability of clinical consultation and training for primary care providers and other health care providers will improve overall mental health care to beneficiaries.

Subsection (b) is necessary to establish the MHPs' obligation to participate in the management of beneficiaries' overall care to ensure inappropriate treatment is not provided due to lack of knowledge. This is particularly important in the area of prescription drugs for beneficiaries who have multiple prescriptions. This subsection includes a statement of the MHPs' obligation to maintain the confidentiality of medical records to make it clear that this regulation does not supersede these requirements.

Subsection (c) is necessary to establish the MHPs' obligation to coordinate with pharmacies and MCPs in order to assure that beneficiaries receive pharmacy and/or laboratory services prescribed through the MHP or its providers. Pharmacy and

laboratory services are not directly under the MHPs' control. It is therefore necessary to establish cooperative working relationships between the MHPs and pharmacies, laboratories, and MCPs, since these services are essential components of mental health treatment.

Subsection (d) is necessary to require the MHP to refer a beneficiary to appropriate physical health based treatment if the beneficiary does not meet medical necessity criteria based on diagnosis, but does require treatment, or if the beneficiary's condition would be amenable to physical health care based treatment. The subsection further clarifies that the MHP is not responsible for making sure the beneficiary actually finds a provider or receives the services to which the beneficiary is referred. This limit is set because without it MHPs would be considered ultimately responsible for all care for beneficiaries, rather than the scope of covered services intended in this chapter. The responsibility to assure appropriate access to care not covered by MHPs rests with the Medi-Cal program as a whole.

Section 1810.425. Hospital Selection Criteria.

Specific Purpose: Section 1810.425 requires that all hospitals under contract to an MHP meet the same basic criteria and also allows MHPs to add requirements if necessary.

Rationale for Necessity: Subsections (a)(1)-(5) are necessary to set out prescribed requirements for each hospital. These provisions are all pre-existing conditions specified in either AB 757, Medi-Cal Program regulations, the federal waiver, or other State or federal law. They are repeated here for the purpose of clarity and for the convenience of MHPs and hospitals.

Subsection (b) is necessary because it indicates that there are additional conditions that may be considered in selecting hospitals. This subsection provides interested parties a general idea of the variety of elements that could be considered in the hospital selection process. Specific elements of consideration are found in each MHP's Implementation Plan.

Subsections (b)(1)-(4) are necessary because they list the other conditions an MHP may consider in the selection process. These provisions are drawn from existing State and federal law, the federal waiver, or derived from the requirements of the authorizing legislation.

Section 1810.430. Contracting for Psychiatric Inpatient Hospital Service Availability.

Specific Purpose: Section 1810.430 sets the parameters for MHPs to enter into contracts with providers of psychiatric inpatient hospital services to assure access to services for beneficiaries.

Rationale for Necessity: Subsections (a) and (b) are necessary to establish the MHPs' obligation to contract with two classes of providers, DSHs and traditional

hospitals, which are identified on the basis of their historic provision of services to Medi-Cal and other low-income populations. This subsection provides that DSHs and traditional hospitals are not exempt from meeting each MHP's hospital selection criteria to ensure that the requirement to contract with these hospitals does not impact quality of care. The Department will notify MHPs which hospitals are DSHs and traditional hospitals on an annual basis. The Department has determined that it would be impractical administratively for the Department and the MHPs to deal with changes to the qualifying hospitals on a more frequent basis.

Subsection (c) is necessary to provide a process for obtaining exemptions from the requirement to contract with DSHs and traditional hospitals. Subsection (c)(1) standardizes the content requirements for a request for exemption. A requirement specifying the database to be used to assess the impact of the exemption on access is necessary to ensure an acceptable level of accuracy. Data on hospital utilization from the Office of Statewide Health Planning and Development is generally regarded as the most complete database that is publicly available. However, if this data is not available or if other data is more complete, an exception is provided.

Subsections (c)(2) and (3) are necessary to establish the Department's obligation to inform affected hospitals of an exemption request, the criteria for approving requests for exemption and the Department's obligation to act on request for exemption in a timely manner. Mention of local community standards allows for differing needs of beneficiaries to obtain access to psychiatric inpatient hospital services, depending on the beneficiary population in both urban and rural areas. "Hardship to beneficiaries" means difficulties in obtaining access to inpatient psychiatric hospital services. "Local community standards" means as compared to the existing ability for the general population to obtain these services in the community. Each instance of such hardship must be evaluated on a case by case basis by the Department with each affected community's prevailing standards judged against conditions where there could be one or more hospitals deleted from the MHP's contracted provider network. A 30-day time period for the Department to approve or deny a request for exemption was chosen as a reasonable time to assess the request.

Subsection (d) is necessary to specify minimum requirements that must appear in all contracts between hospitals and MHPs. These standardized requirements are necessary to assure that minimum performance standards exist statewide, that State and federal legal and regulatory requirements are met, and that beneficiaries have adequate access to quality care.

Subsection (e) is necessary to clarify that hospital contracts under this chapter may not supersede the duties and obligations of county patient's rights advocates as specified in the Welfare and Institutions Code.

Subsection (f) is necessary to clarify that a separate, formal contract is not necessary when the MHP itself owns or operates the hospital that is providing services.

Section 1810.435. MHP Individual, Group, and Organizational Provider Selection Criteria.

Specific Purpose: Section 1840.435 requires the MHP to ensure that all individual, group, or organizational providers under contract to an MHP meet the same minimum standards and also allows the MHPs to add requirements if necessary.

Rationale for Necessity: Subsection (a) is necessary to specify the responsibility of the MHPs to establish selection criteria for providers and clarify for the MHPs and other affected parties that the selection criteria must comply with the terms of the contract between the MHP and the Department and the MHP's Implementation Plan in addition to the requirements of this section. The Department expects that the contracts between the Department and the MHP will provide specific methods for ensuring that criteria contained in this regulation are met, rather than adding new areas that must be considered by the MHP.

Subsections (b)(1)-(5) are necessary to prescribe requirements for each individual or group provider. These are all pre-existing conditions specified in either AB 757, Medi-Cal program regulations, the federal waiver, or other state or federal law. They are repeated here for the purpose of clarity and for the convenience of MHPs and providers.

Subsection (b)(6) is necessary to allow MHPs to add requirements above the minimum that would help maintain a quality provider network under the unique circumstances of each individual county's provider pool and situation.

Subsections (c)(1)-(9) are necessary to prescribe requirements for each organizational provider. These are all pre-existing conditions specified in either AB 757, Medi-Cal Program regulations, the federal waiver, or other State or federal law. They are repeated here for the purpose of clarity and for the convenience of MHPs and providers. The requirements for organizational providers are different than the requirements for individual and group providers to accommodate differences in the delivery of services and reimbursement for these providers. Appropriate supervision of staff must be established because organizational providers may use non-licensed persons to provide services. Appropriate accounting practices must be established because organizational providers must are required to submit cost reports as part of their reimbursement process.

Subsection (c)(10) is necessary to allow MHPs to add requirements above the minimum that would help maintain the quality of organizational providers according to the unique circumstances of each county's local community standards or to obtain specialized providers, such as child psychiatrist or providers with a particular expertise in cultural competence.

Subsection (d) is necessary to require the MHP to certify that providers of specialty mental health services, other than those provided directly by the MHP, meet the standards listed in subsections (b) and (c). This subsection also requires the MHP to conduct an on site review of organizational providers in order to ascertain that these providers comply with these same standards prior to certification for provision of

services. The on site review provides assurance that all requirements are met. The subsection also provides for different timelines for certification to be established in the contract between the Department and the MHP primarily to allow the Department and the MHP to waive a formal certification process for providers who were certified for the Department to participate in the Short-Doyle/Medi-Cal program, which provided mental health services to Medi-Cal beneficiaries immediately prior to the implementation of the Medi-Cal Specialty Mental Health Services Consolidation program described in this chapter.

Subsection (e) mandates the Department to conduct the on-site certification process for those organizational providers that are owned or operated by the MHP. This is necessary to prevent the appearance of or actual conflicts of interest on the part of the MHP for these providers. The same provision for modifying timelines is allowed for the Department as is allowed for MHPs.

Section 1810.436. MHP Individual, Group, and Organizational Provider Contracting Requirements.

Specific Purpose: Section 1840.436 sets the parameters for MHPs to enter into contracts with individual, group and organizational providers to ensure access to services for beneficiaries.

Rationale for Necessity: Subsections (a)(1)-(5) are necessary to provide the minimum standards for contracts between MHPs and specialty mental health providers. These standardized requirements must be met in all contracts between MHPs and their contracts with individual, group, and organizational providers to assure that minimum standards exist statewide, that State and federal legal and regulatory requirements are met, and that provision of services to beneficiaries is of the same standard as to all other patients.

Subsection (b) is necessary to clarify that individual, group and organizational provider contracts under this chapter may not supersede the duties and obligations of county patient's rights advocates as specified in the Welfare and Institutions Code.

Section 1810.438. Alternative Contracts and Payment Arrangements Between MHPs and Providers.

Specific Purpose: Section 1810.438 requires the Department to approve contracts between the MHP and a provider where that provider is responsible for services whether or not they are delivered by a different provider and where a payment arrangement with contract or non-contract providers would not be allowed under the Chapter without approval under this Section.

Rationale for Necessity: Subsections (a) is necessary to describe the types of contracts and payment arrangements covered by this Section. This Subsection allows the Department to approve proposals that are not consistent with other sections of this Chapter only when specific authority to do so is provided under the other sections. The sections that include this authority are:

Section 1820.110. Rate Setting for Psychiatric Inpatient Hospital Services for Negotiated Rate, Fee-for-Service/Medi-Cal Hospitals.

Section 1820.120. Rate Setting for Psychiatric Inpatient Hospital Services for Short-Doyle/Medi-Cal Hospitals.

Section 1820.220. MHP Payment Authorization by Point of Authorization.

Section 1830.105. Provider Rate Setting Standards and Requirements.

Section 1830.115. Psychiatric Nursing Facility Rates.

Subsections (b) and (c) are necessary to establish that MHPs must provide sufficient information to the Department to determine if the proposed contract or payment arrangement meets state and federal reimbursement and data reporting requirements. MHPs and their contractors want flexibility in contract reimbursement methodologies to share the risk of specialty mental health services to beneficiaries. Because of the wide variety of potential strategies that MHPs may want to employ, it is not feasible to establish specific requirements in regulation that will ensure compliance with the intent of federal and state reimbursement and data reporting requirements. The Department's case by case review of the description of individual contracts will allow MHPs maximum flexibility while allowing the Department to ensure compliance with applicable state and federal requirements.

Subsection (d) is necessary to establish that contracts between the MHP and a Fee-for-Service/Medi-Cal hospital that include psychiatric inpatient hospital professional services pursuant to Section 5781 of the Welfare and Institutions Code do not require approval from the Department. The Department has determined that Department review is not necessary because the potential for duplicate billing does not exist in this arrangement, since different billing systems are used for hospital per diem payments and professional services.

Subsection (e) is necessary to clarify that this section does not affect existing requirements in the Health and Safety Code regarding licensure as a health care service plan or specialized health care service plan, which may be applicable to some providers contracting with the MHPs for alternative reimbursement structures.

Subsection (f) is necessary to specify that a capitation or case rate established under this subsection is not a rate that may be used to establish a provider's usual and customary charges for the purpose of other billing of the Medi-Cal program by that provider. Providers are typically prohibited from seeking payment from the Medi-Cal program that exceeds the lowest rate they charge other patients. Although capitated and case rates are not strictly comparable to fee-for-service rates, it is necessary to clarify that these risk-based rates do not constitute a new usual and customary charge because risk-based rates may not be familiar to providers and others who may be responsible to determine appropriate charges under the Medi-Cal program.

Section 1810.440. MHP Quality Management Programs.

Specific Purpose: Section 1840.440 explains the minimum requirements of the Quality Management Program (QMP) to be established by MHPs based on the terms of the contract between the MHP and the Department. The QMP ensures that basic quality of care and utilization control standards are met.

Rationale for Necessity: Subsection (a) is necessary to require that the QMP include a Quality Improvement Program (QIP) responsible for reviewing quality of care. Subsections (1), (5) and (6) are necessary to ensure organizational commitment to the QIP by making the QIP accountable to the highest level mental health professional within the MHP's organization by requiring specific monitoring activities by the MHP, and requiring annual review of the program. An annual review was established consistent with industry standards for QMPs. Subsections (2) and (4) are necessary to ensure that individuals with relevant perspectives on quality of care are involved in the QIP. Subsection (3) is necessary to clarify that MHPs may not discriminate against participants in the QIP for their QIP activities.

Subsection (b) is necessary to establish the requirement that the QMP include a Utilization Management Program (UMP) responsible for assuring that the MHP provides appropriate access to care consistent with the requirements of this chapter. An annual review was established consistent with industry standards for QMPs.

Subsection (c) is necessary to assure beneficiaries and providers that MHPs must meet established standards for the maintenance of beneficiary records. Specific standards are provided for signatures on client plans by treating professionals or other representatives of the MHP and by beneficiaries, because these are areas that most directly affect treating professionals and beneficiaries.

Subchapter 2. Medi-Cal Psychiatric Inpatient Hospital Services

Article 1. Fiscal Provisions

Section 1820.100. Definitions.

Specific Purpose: Section 1840.100 identifies the specific meanings of terms used in this article.

Rationale for Necessity: Subsection (a) is necessary to establish a single term for use in this article to describe the codes applicable to rate setting for Fee-for-Service/Medi-Cal hospitals. The codes selected are the same codes used to bill the fiscal intermediary for psychiatric inpatient hospital services in the regular Medi-Cal program, with the exception of 097. Code 097 has been established to allow hospitals and the MHPs to negotiate a separate rate for minors, who often require more intensive and, therefore, more costly services, even though there is currently no allowable billing code that meets this need. Additional information on the use of this code is provided in DMH Information Notice No. 03-08 dated August 27, 2003.

Subsection (b) is necessary to clarify that it is the actual physical location of the hospital that is critical for rate-setting purposes, rather than a location such as a corporate headquarters.

Subsection (c) is necessary to clarify a term used to describe a type of hospital reimbursement that may not be widely understood.

Section 1820.110. Rate Setting for Psychiatric Inpatient Hospital Services for Negotiated Rate, Fee-for-Service/Medi-Cal Hospitals.

Specific Purpose: Section 1820.110 specifies the requirements and procedures for rate setting by an MHP with Fee-for-Service/Medi-Cal hospitals who are entering into a contract with any MHP for psychiatric inpatient hospital services.

Rationale for Necessity: The regulation is necessary because, while general authority for rate setting by MHPs is included in AB 757, the rate setting process is unspecified.

Subsection (a) is necessary to establish that the basis for reimbursement to Fee-for-Service/Medi-Cal hospitals for acute psychiatric inpatient hospital services will be a per diem rate that is negotiated between an MHP and the hospital, unless the MHP has obtain approval for an alternative rate process pursuant to Section 1810.438. These subsections are also necessary to establish that the MHP serving the county in which the hospital is located, with certain exceptions, is responsible for negotiation of the rate that will apply to all MHPs using that hospital. The exceptions are necessary to eliminate the possibility of duplicate negotiations between MHPs and hospitals or multiple rates being set by different MHPs for the same hospital.

The exception in (a) (1) allows an MHP to delegate its authority to establish rates to another MHP. This is an important exception in the event the MHP for the county in which a hospital is located is not interested in establishing a rate for a hospital in the county, primarily due to low beneficiary usage of the facility. An MHP serving a different county could be a more frequent user.

The exception in (a)(2) provides for negotiation of a rate by a designated MHP if the MHP that would ordinarily be responsible for the negotiation declines to negotiate with the hospital or is exempted from negotiation but does not delegate its authority to another MHP or if there is no MHP currently operating in the county in which the hospital is located.

The exemption in (a)(3) allows an MHP to establish rates with an out-of-state hospital in a border community in which California beneficiaries customarily obtain care.

The exemption in (a)(4) arises if the MHP owns or operates the hospital in question. In this case, the approval for the rate must be obtained from the Department. The Department must then approve the rate as long as the rate is not greater than the highest rate negotiated under this section by any MHP. This ensures that MHPs that own or operate Fee-for-Service/Medi-Cal hospitals will not use this rate setting process to obtain an inappropriately high level of FFP for services provided in these hospitals.

Subsection (b) is necessary to specify the components of the per diem rate, which is the basis for all negotiations. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Subsection (c) is necessary to clarify the relationship between rates and allowable psychiatric accommodation codes and to specify that the rates negotiated by an MHP with a hospital are the same rates used by other MHPs in their transactions with the same hospital. These provisions eliminate the possibility of different rates being paid by different MHPs for similar services to beneficiaries. This subsection is also necessary because rates, once set, will not be subject to retrospective adjustments to cost. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Subsection (d) is necessary to define the method of rate setting for administrative day services including the associated hospital-based ancillary services, which has been standardized statewide consistent with the rates established for these services in the regular Medi-Cal program. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Subsection (e) is necessary to clarify that the amount paid to the hospital will be reduced by the reimbursement amount that is the responsibility of third party payers or a beneficiary with a share of cost.

Subsection (f) is necessary to specify that hospitals bill the MHP their usual and customary charges, regardless of the rate negotiated under this section. This provides documentation that the hospital has complied with federal and state requirements for the Medi-Cal program that prohibit providers from charging the Medi-Cal program more than their usual and customary charges to other patients. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438, because under many alternative contracting arrangements (e.g., capitation or case rates), providers are not required to bill for individual services.

Subsection (g) is necessary to clarify that, while the hospital bills its usual and customary charges as provided in (f), the Department will annually verify that the negotiated rates do not exceed usual and customary charges. If they do, future claims will offset the overpayment. Federal law requires that the rate paid may not be more than usual and customary charges. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Subsection (h) is necessary to specify to hospitals that the payment under this section, less third party liability and patient share of costs is payment in full for services provided. This provision is intended to prevent hospitals from expecting to bill beneficiaries for the difference between the negotiated rate and the hospital's usual and customary charges. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Subsection (i) is necessary to clarify that the MHPs are not responsible for reimbursement of Medicare coinsurance and deductible payments that may be due to the provider through the Medi-Cal program.

Section 1820.115. Rate Setting for Psychiatric Inpatient Hospital Services for Non-negotiated Rate, Fee-for-Service/Medi-Cal Hospitals.

Specific Purpose: Section 1820.115 specifies the requirements and procedures for rate setting for psychiatric inpatient hospital services for Fee-for-Service/Medi-Cal hospitals that have not negotiated a rate with an MHP under Section 1820.110.

Rationale for Necessity: The regulation is necessary because, while specific authority for rate setting by MHPs is included in law, no process for establishing rates of reimbursement of Fee-for-Service/Medi-Cal hospitals that do not have a contract with any MHP is included. Since psychiatric inpatient hospital services may be provided by non-contract hospitals in an emergency and must be reimbursed by MHPs, it is necessary to establish a reimbursement rate for these services.

Subsections (a)(1)-(3) are necessary to establish that the Department is responsible to set rates for each allowable psychiatric accommodation code for acute psychiatric inpatient hospital services within each specified geographical region. The process is established on an annual basis and prior to the end of the fiscal year because the Department determined that this was the most likely time frame for MHPs to renegotiate their hospital contracts, which form the basis of the rates established under this section.

Subsection (b) is necessary because it delineates the components of the per diem rate, the basis for all reimbursement amounts.

Subsection (c) (1) and (2) are necessary because they describe the actual calculation of per diem rates by accommodation code for non-negotiated rate, Fee-for-Service/Medi-Cal hospitals for psychiatric inpatient hospital services and how this rate is actually determined. The calculation is based on an average of all negotiated rates within each specified geographical area as the only equitable way to establish a rate that provides reasonable reimbursement to non-contract hospitals without establishing a disincentive to contract with MHPs.

Subsection (d) is necessary to establish the rate for administrative day services and associated hospital-based ancillary services. The provision duplicates the provisions of Section 1820.110, but is repeated to provide all the requirements applicable to non-negotiated rate Fee-for-Service/Medi-Cal hospitals in one section.

Subsections (e)-(h) are necessary to specify reimbursement conditions applicable to the hospitals covered by this section. The provisions duplicate the provisions of Section 1820.110, but are repeated to provide all the requirements applicable to non-negotiated rate Fee-for-Service/Medi-Cal hospitals in one section.

Subsections (i)(1)-(5) are necessary to establish the geographical areas that will be used for the calculation of rates by the Department. The rate regions are based on

groups of counties that have historically worked cooperatively on mental health issues and are likely to be using the same hospitals. Border communities have been assigned based on their proximity to the counties included in the rate region.

Subsection (j) is necessary to clarify that the MHPs are not responsible for reimbursement of Medicare coinsurance and deductible amounts that may be due to the provider through the Medi-Cal program.

Section 1820.120. Rate Setting for Psychiatric Inpatient Hospital Services for Short-Doyle/Medi-Cal Hospitals.

Specific Purpose: Section 1820.120 establishes the process that will be used by MHPs and the Department to set rates for Short-Doyle/Medi-Cal hospitals.

Rationale for Necessity: This regulation is necessary because, while authority for rate setting by MHPs is included in law, the specifics are undefined. The rate setting process established is the process established for these hospitals in the Welfare and Institutions Code under the Medi-Cal program prior to implementation of the program described in this chapter. The regulation cross-references the description of the rate setting process in Subchapter 4, rather than repeating the process here. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Article 2. Provision of Services

Section 1820.200. Definitions.

Specific Purpose: Section 1820.200 identifies the meaning of terms in this article.

Rationale for Necessity: Subsection (a) is necessary to describe specifically what an adverse decision is in terms of this article because the term may otherwise be understood more broadly or narrowly than intended.

Subsection (b) is necessary to assure that there is consistency in meaning and application of this program term in the Medi-Cal Program administered by either the Department or the State Department of Health Services. Consistency is necessary to assist hospitals to understand program requirements.

Subsection (c) is necessary to describe a specific program referenced in this article that serves persons who are medically indigent and not covered by the Medi-Cal program.

Subsection (d) is necessary to provide a single term of reference for a type of admission to psychiatric inpatient hospital services because requirements of this article vary considerably between two types of admissions.

Subsection (e) is necessary to provide a single term of reference for a type of admission to psychiatric inpatient hospital services because requirements of this article vary considerably between two types of admissions.

Subsection (f) is necessary to describe a specific type of committee referenced in this article.

Section 1820.205. Medical Necessity Criteria for Reimbursement of Psychiatric Inpatient Hospital Services.

Specific Purpose: Section 1820.205 provides standardized clinical criteria, commonly referred to as medical necessity criteria, to be used by MHPs to determine if psychiatric inpatient hospital services for a particular beneficiary are covered by the MHP and payment authorization for the hospital is warranted.

Rationale for Necessity: The regulation is necessary to assure that the definition of medical necessity is uniform for all MHPs as required by state law.

Subsections (a)(1) and (2) are necessary to establish the medical necessity criteria that must be met before an MHP will be responsible to pay a hospital for psychiatric inpatient hospital services. The diagnoses and factors identifying the severity of the beneficiary's condition were determined by the Department based on input from clinicians and other interested parties developed during the public planning process. The severity criteria in these subsections are consistent with requirements as applied by the Medi-Cal program administered by the State Department of Health Services. The diagnostic criteria reflect the Fourth Edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. This volume is the standard reference for clinical diagnoses in the mental health field.

Subsections (b)(1)-(4) are necessary to specify variations in the medical necessity criteria that are applicable to continued stay services because these variations may not be clearly understood as part of the criteria as stated in subsection (a). These subsections are consistent with requirements as applied by the Medi-Cal program administered by the State Department of Health Services.

Section 1820.210. Hospital Utilization Control.

Specific Purpose: Section 1820.210 incorporates by reference federal requirements for utilization control and the establishment of a Utilization Review Committee (URC) to administer utilization control procedures. It also incorporates federal requirements for committee composition.

Rationale for Necessity: The regulation is necessary to clarify that federal hospital utilization control requirements apply to the program implemented by this chapter.

Section 1820.215. MHP Payment Authorization - General Provisions.

Specific Purpose: Section 1820.215 establishes general provisions for MHPs to apply when authorizing payment for psychiatric inpatient hospital services.

Rationale for Necessity: This regulation is necessary because state law mandates that the minimum scope of benefits be the same for all beneficiaries. In order to achieve this end, it is necessary to establish uniform baseline requirements for all MHPs to apply when reviewing a request for MHP payment authorization.

Subsection (a)(1) and (2) are necessary to specify where responsibility for payment authorization resides since the actual agent of authorization may vary by type of hospital, either Fee-for-Service/Medi-Cal or Short-Doyle/Medi-Cal.

Subsection (b) is necessary to establish that authorization brings with it the obligation to pay for the approved services in accordance with this chapter. This subsection is also necessary to clarify for an MHP its responsibilities for persons who are covered by the County Medical Services Program (CMSP), which provides services to individuals who are medically indigent and not covered by the Medi-Cal program. An administrative agreement was reached between the Department, CMSP and the State Department of Health Services that MHPs would process CMSP treatment authorization requests for MHP payment authorization to simplify claims processing for CMSP. MHPs are not responsible for paying for the services they authorized for CMSP eligible individuals. Including this provision in the regulations will simplify and clarify what could be a potentially confusing and conflicting issue.

Subsection (c) is necessary to establish the conditions under which late MHP payment authorization requests must be considered by the MHP and to provide authority for the MHP to determine other acceptable reasons for late submission of payment authorization requests.

Subsections (c)(1) and (2) are necessary to identify acceptable reasons for late submission and specify the necessary documentation from hospitals if any of these exceptions are claimed. Subsection (c)(3) is necessary to identify reasons or justifications that would not excuse an untimely submission. The timelines established in these regulations are consistent with similar provisions for late submissions established for the regular Medi-Cal program.

Section 1820.220. MHP Payment Authorization by a Point of Authorization.

Specific Purpose: Section 1820.220 establishes the specific procedures and timelines for MHPs to apply when the MHP payment authorization is done by a point of authorization.

Rationale for Necessity: Subsection (a) is necessary to indicate when hospitals must submit documentation to an MHP for payment authorization. In general, separate documentation is required whenever the beneficiary has experienced a change in status in terms of an inpatient hospital stay such as admission, discharge, a change in the kind of psychiatric inpatient services provided or when the necessity of a continued stay is being disputed and the regulation governing aid paid pending a fair hearing applies. Ninety-nine days is specified because the regular Medi-Cal program requires that documentation for a stay is valid for a maximum of 99 calendar days of continuous service. Most authorizations by a point of authorization will be for services provided in a

Fee-for-Service/Medi-Cal hospital. These claims will be processed and paid by the fiscal intermediary that also processes hospital claims for the regular Medi-Cal program. Using the same limitation allows the fiscal intermediary to process claims more efficiently overall.

Subsection (b) is necessary to provide specific deadlines for each of the documentation requirements specified in (a). These time requirements match the time requirements currently applied by the Medi-Cal program as operated by the State Department of Health Services.

Subsection (c) is necessary to specify for hospitals and MHPs the forms and documentation requirements that may be required when a payment authorization is submitted. These sections are necessary because different categories of hospitals have different requirements. The requirements were designed to be consistent with existing practice as much as possible both in order to eliminate confusion and to mirror the requirements of the Medi-Cal program as operated by the State Department of Health Services. An exemption is provided when the MHP has obtained Department approval for an alternative contract pursuant to Section 1810.438.

Subsection (d) is necessary to establish the professional qualifications required of MHP point of authorization staff. The requirements were determined by the Department during the public planning process in discussions with clinicians and other interested parties and were selected to be consistent with standard practice in Short-Doyle/Medi-Cal programs prior to implementation of the Medi-Cal Psychiatric Inpatient Hospital Services Consolidation program, which was regulated in Title 9, CCR, Chapter 10.

Subsection (e) is necessary to establish the specific documentation requirements of the point of authorization for its approval or disapproval of MHP payment authorization requests. This provision will facilitate processing time required when a dispute arises or for reviews by oversight agencies. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Subsection (f) is necessary to establish that the MHP must provide physician or psychologist review of MHP payment authorization requests that have been denied due to a lack of medical necessity. This provision will assure a higher level of clinical oversight of the decisions where the consequences to the hospital and, in some cases, to the beneficiary, are greater.

Subsection (g) restates that an MHP payment authorization must meet the timelines set forward in these regulations. This duplication is necessary to assure that hospitals understand that documentation must be submitted in the prescribed manner or substantial financial losses could result.

Subsection (h) is necessary to ensure consistent and timely processing of MHP payment authorization requests so that hospitals may receive timely payment for approved stays or so that beneficiaries and hospitals may make reasonable alternative plans if a request is denied by an MHP. Subsection (h) also provides for an expedited

review of an MHP payment authorization request for a planned admission in accordance with the timelines in Title 42, CFR, Section 438.210(d)(2).

Subsection (i) is necessary to allow MHP authorization staff some latitude in scheduling the approval and processing of paperwork. The subsection will allow advance approval up to a specified limit. The seven-day time limit is set so these regulations will be consistent with the Medi-Cal program as operated by the State Department of Health Services.

Subsection (j)(1) is necessary to establish the conditions under which an MHP must approve a payment authorization request for a planned admission, clarifying all the conditions that must be met. To assure equity for beneficiaries, hospitals and MHPs, conditions for approval must be clearly stated so they can be consistently applied.

Subsection (j)(2) is necessary to clarify that emergency admissions may not be subject to authorization in advance of the admission. It is a condition of the approved federal waiver for the program governed by this chapter that emergency services may not be subject to prior authorization. This provision is designed to assure that beneficiaries' access to services in an emergency is not impaired by the program.

Subsection (j)(3) is necessary to establish timelines for submission of requests for continued stay services. The timeline requirements for hospitals are consistent with the timelines established for the regular Medi-Cal program operated by the State Department of Health Services.

Subsection (j)(4) is necessary to establish the conditions under which an MHP must approve a payment authorization request for acute psychiatric inpatient hospital services, as opposed to administrative day services, for a continued stay. This subsection also clarifies that the MHP payment authorization procedures in this subsection do not negate terms of the contract between an MHP and hospital. Terms of these contracts, however, would be superseded by the regulations in this chapter if there were a direct conflict as provided in Section 1810.110. To assure equity for beneficiaries, hospitals and MHPs, conditions for approval must be clearly stated so they can be consistently applied.

Subsection (j)(5)(A)-(B) is necessary to establish requirements for approval of administrative day services. Beneficiaries are approved for administrative day services when they are no longer acute and do not fit the medical necessity criteria, and the hospital and MHP are awaiting placement of the beneficiary in an appropriate facility for a lower level of care. Hospitals are required to make and document specific efforts to find an appropriate placement to ensure that beneficiaries do not remain in the hospital any longer than necessary. The number of times that the hospital must make these efforts is set at five times per week, as the Department has determined that this is a reasonable balance between the needs of the beneficiaries for timely and appropriate placement on discharge and the administrative burden for hospitals.

Subsection (j)(5)(C) provides an alternative mechanism if the alternative meets the intent of the subsection for timely discharge.

Subsection (j)(5)(D) clarifies that the MHP payment authorization procedures in subsection (j)(5) do not negate terms of the contract between an MHP and hospital. Terms of these contracts, however, would be superseded by the regulations in this chapter if there were a direct conflict as provided in Section 1810.110.

Subsection (j)(6) is necessary to establish the MHP's responsibility to authorize services regardless of the MHP's assessment of medical necessity in those situations under the Medi-Cal program that provide the beneficiary the right to continued services when there is a dispute between the MHP and the beneficiary's provider about whether services are medically necessary and the beneficiary acts on a timely basis to request a fair hearing on the issue. The right to continued services in these situations is typically called aid paid pending a fair hearing.

Section 1820.225. MHP Payment Authorization for Emergency Admissions by a Point of Authorization.

Specific Purpose: Section 1820.225 establishes general provisions for an MHP point of authorization to apply when authorizing payment for emergency admissions.

Rationale for Necessity: This regulation is necessary because the procedures for MHP payment authorization of emergency admissions differs substantially from that required for planned admissions. It is imperative that the requirements be clearly differentiated so timely provision of emergency care is not impacted and hospitals that provide emergency care are assured of appropriate reimbursement.

Subsection (a) is necessary to repeat the provision already stated in the previous regulation that emergency admissions are exempt from MHP prior authorization for admission. This is such an important issue for timely processing of an emergency admission that this repetition is necessary for clarity. This subsection also clarifies that the prohibition against prior authorization applies whether the admission is voluntary or involuntary to prevent confusion with legal requirements dealing with the treatment of mental illness outside the scope of this chapter that do make a distinction between voluntary and involuntary admissions.

Subsection (b) is necessary to clarify that an emergency admission must meet the medical necessity criteria and must meet emergency psychiatric condition criteria.

Subsection (c) is necessary to establish that the hospital providing emergency services must notify the MHP when an emergency admission has occurred within a specified timeline. Prompt notification is necessary to allow the MHP to begin coordination of care for the beneficiary as soon as possible. Notification also allows the MHP, at its election, to begin the formal MHP payment authorization process at the earliest possible point after the beneficiary has been admitted. The timeline is within 24 hours of the admission, or the timeline specified in the contract between the MHP and the hospital. The 24-hour timeline is consistent with the timeline for notification of emergency admissions applicable to the regular Medi-Cal program and is a balance between the MHP's need to know and the hospital's administrative capacity to identify the beneficiary

and the responsible MHP. The subsection provides that the 24-hour timeline will be superseded by a timeline agreed by the MHP and a hospital in the contract negotiation process to allow a timeline more appropriate to the specific MHP and hospital to be established between the two parties.

Subsection (d) is necessary to establish the criteria by which MHP payment authorization for emergency admissions will be approved for payment. To assure equity for beneficiaries, hospitals and MHPs, conditions for approval for emergency admissions must be clearly stated so they can be consistently applied. These requirements are consistent with those stated in the previous section of these regulations for other categories of service. The necessity for 24-hour notification in (d)(1) has already been provided in the rationale for subsection (c) above.

Subsection (d)(2) provides that written documentation must state that the beneficiary has met medical necessity criteria in addition to the notification requirement.

Subsection (d)(3) makes it clear that it is not only necessary that beneficiaries meet medical necessity requirements for admission, but that they must continue to meet the medical necessity requirements for each day that is deemed to be an acute day rather than an administrative day.

Subsection (d)(4) is necessary to protect the hospital, the beneficiary and the MHP in the event that questions arise when the MHP payment authorization for the emergency admission in a non-contract hospital is presented for approval.

Subsection (d)(5) is necessary to clarify that the MHP payment authorization procedures in this section do not negate terms of the contract between an MHP and hospital. Terms of these contracts, however, would be superseded by the regulations in this chapter if there were a direct conflict as provided in Section 1810.110.

Subsection (e) is necessary to provide flexibility for the MHP to contain costs and utilize contract hospitals while assuring that beneficiaries are provided with necessary care.

Section 1820.230. MHP Payment Authorization by a Utilization Review Committee.

Specific Purpose: Section 1820.230 establishes the specific procedures and timelines for MHPs to apply when the MHP payment authorization is done by a URC.

Rationale for Necessity: Subsection (a) is necessary to establish the MHP's authority to use a Short-Doyle/Medi-Cal hospital's URC to perform the MHP payment authorization function. The URC provides the same functions as a point of authorization. Subsection (a)(1) incorporates by reference federal requirements for participants in the URC process. Subsection (a)(2) establishes a documentation requirement for the URC to ensure there is a written record of the URC's decision to facilitate processing time required when a dispute arises or for reviews by oversight agencies.

Subsection (b) is necessary to set a time requirement for payment authorization by a URC. The timeline is set at three working days, rather than the 14 calendar days allowed for a point of authorization, because timely action is important for both the hospital and the MHP and because processing time is less when the process is accomplished within the hospital, rather than through a separate entity.

Subsection (c) is necessary to assure that MHP payment authorization is not open-ended and will be reviewed at a specified time.

Subsection (d)(1) is necessary to define the criteria by which URC shall approve a payment authorization. To assure equity for beneficiaries, hospitals and MHPs, conditions for approval must be clearly stated so they can be consistently applied.

Subsection (d)(2) is necessary to distinguish the documentation requirements between those for acute inpatient hospital services and administrative day services. The procedures for documentation of administrative days mirror the procedures applied in Fee-for-Service/Medi-Cal facilities to assure statewide consistency.

Subchapter 3. Specialty Mental Health Services Other than Psychiatric Inpatient Hospital Services

Section 1830.100. General Provisions.

Specific Purpose: Section 1830.100 provides that the specialty mental health services covered by Subchapter 4 do not include psychiatric inpatient hospital services.

Rationale for Necessity: This regulation is necessary to simplify references to the specialty mental health services covered by this Subchapter. Without this regulation, each time the term “specialty mental health services” is used in this Subchapter the reference would need to say “specialty mental health services, other than psychiatric inpatient hospital services.”

Article 1. Fiscal Provisions

Section 1830.105. Provider Rate Setting Standards and Requirements.

Specific Purpose: Section 1830.105 specifies the requirements and procedures for rate setting by an MHP for providers of specialty mental health services covered by this subchapter.

Rationale for Necessity: This regulation is necessary to specify rate setting by MHPs, which was authorized in AB 757, but without detailed procedures.

Subsection (a) is necessary to establish rates for specialty mental health services for organizational providers with or without contractual agreements with the MHP in accordance with Section 1840.105 of this chapter. The process described in Section 1840.105 is the process established in state law for these types of providers to ensure compliance with federal law, regulations, and guidelines governing these types of

providers. An exemption is provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Subsection (b) is necessary to make it clear that MHPs may negotiate rates with group and individual providers with whom it has contractual agreements.

Subsection (c) is necessary to establish the rates that must be paid to individual and group providers that do not have a contract with the MHP, except when these providers deliver psychiatric inpatient hospital professional services to a beneficiary with an emergency psychiatric condition. The MHP may authorize non-contract providers to deliver services to meet the routine or urgent needs of a beneficiary, particularly if the beneficiary is out of the county. This subsection sets a reasonable guideline for providers and the MHPs in these situations. The basic rates are the rate established by the regular Medi-Cal program for these services, but flexibility is provided for the MHP and the provider to agree to other rates.

Subsection (d) is necessary to establish the rates that must be paid to individual and group providers that do not have a contract with the MHP when these providers deliver psychiatric inpatient hospital professional services to a beneficiary with an emergency psychiatric condition. The rate is mandatory to prevent misunderstandings between the MHP and the provider in a situation that typically provides no opportunity to reach agreement on rates prior to the delivery of services. The rates are the rates established by the regular Medi-Cal program for these services.

Subsections (e) and (f) are necessary to specify the conditions that affect the provider's actual reimbursement for the specialty mental health services covered by this subchapter. The conditions parallel those established for psychiatric inpatient hospital services in Sections 1820.110, 1820.115, and 1820.120.

Subsection (g) is necessary to clarify that the MHP is not responsible for reimbursement of Medicare coinsurance and deductible amounts that may be due to the provider through the Medi-Cal program, unless the provider is an organizational provider, including the MHP, and is also the Medicare provider of the service to which the coinsurance or deductible payment applies. The exception is provided because the cost report and negotiated rate processes referenced in Section 1840.105 include appropriate adjustments these amounts.

Section 1830.115. Psychiatric Nursing Facility Rates.

Specific Purpose: Section 1830.115 establishes the rate for psychiatric nursing facility services as the rate for similar services established for the regular Medi-Cal program.

Rationale for Necessity: This regulation is necessary to establish the rates for psychiatric nursing facilities through references to regulations governing nursing facility rates in the regular Medi-Cal program. The rate has been set by the Department rather than allowing the MHPs and the facilities to negotiate rates through a contracting process to minimize the administrative burden on nursing facilities that are willing to provide psychiatric nursing facility services under this chapter. An exemption is

provided when the MHP has obtained Department approval for an alternative rate pursuant to Section 1810.438.

Article 2. Provision of Services

Section 1830.205. Medical Necessity Criteria for MHP Reimbursement of Specialty Mental Health Services.

Specific Purpose: Section 1820.205 provides standardized clinical criteria, commonly referred to as medical necessity criteria, to be used by MHPs to determine if specialty mental health services covered by this subchapter for a particular beneficiary are covered by the MHP and payment to the provider is warranted.

Rationale for Necessity: The regulation is necessary to assure that the definition of medical necessity is uniform for all MHPs as required by state law.

Subsections (a) and (b) are necessary to establish the medical necessity criteria that must be met before an MHP will be responsible to pay a provider for specialty mental health services covered by this subchapter. The diagnoses and factors identifying the beneficiary's level of impairment and the likely effectiveness of an intervention covered by the MHP were determined by the Department based on input from clinicians and other interested parties developed during the public planning process. These elements are modeled upon treatment criteria currently in use in community mental health programs, and take into consideration that effective treatment may occur in the physical health care realm, particularly through primary care. The diagnostic criteria reflect the Diagnostic and Statistical Manual, Fourth Edition of the American Psychiatric Association. This volume is the standard reference for clinical diagnoses in the mental health field.

Subsection (c) is necessary to clarify the responsibility of the MHP to provide specialty mental health services when the medical necessity criteria are met even if the beneficiary has another condition not included in the diagnostic criteria listed in subsection (b)(1). Although this requirement could be inferred from the criteria in subsection (b), it is an issue that could easily be misunderstood by MHPs and beneficiaries and result in the inappropriate denial of care for the included diagnosis. Frequently occurring dual diagnoses include conditions such as substance abuse disorder or mental retardation along with a diagnosis of major depression or schizophrenia.

Section 1830.210 Medical Necessity Criteria for MHP Reimbursement for Specialty Mental Health Services for Eligible Beneficiaries under 21 Years of Age.

Specific Purpose: Section 1830.210 standardizes the criteria used by an MHP to determine if specialty mental health services covered by this subchapter are covered by the MHP and payment to the provider is warranted, when specific medical necessity criteria of Section 1830.205 are not met and the beneficiary is under 21 years of age and eligible for EPSDT services.

Rationale for Necessity: This regulation is necessary to establish medical necessity criteria consistent with federal Medicaid and state Medi-Cal requirements for specialty mental health services covered by this subchapter for beneficiaries under 21 years of age who are eligible for EPSDT services under federal law.

Subsection (a) provides the medical necessity criteria for these children, which differ from those applicable to all other beneficiaries in the criteria used to determine the impairment and appropriateness of an intervention. For these children, a service is generally medically necessary if it corrects or ameliorates the beneficiary's mental illnesses. Specific criteria in this subsection are based on the applicable regulation governing the regular Medi-Cal program, Title 22, Section 51340, with modifications necessary to focus on specialty mental health issues only.

Subsection (b) explains that if other appropriate specialty mental health services covered by this Subchapter are available through the MHP on a timely basis, then requests for EPSDT supplemental specialty mental health services may not be approved. This requirement is consistent with the requirement of Title 22, Section 51340(*l*).

Subsection (c) is necessary because it provides guidelines for the MHP's approval of an EPSDT supplemental specialty mental health service when an institutional level of care may be more cost effective than the EPSDT supplemental specialty mental health service. This requirement is consistent with the requirement of Title 22, Section 51340(m). The determination of whether or not an institutional level of care is available must be consistent with the stipulated settlement in the case of T.L. v. Belshé; therefore, a reference to the settlement is included.

Section 1830.215. MHP Payment Authorization.

Specific Purpose: Section 1830.215 describes the process to be used by MHPs in authorizing payment for services delivered to beneficiaries by providers of specialty mental health services covered by this subchapter.

Rationale for Necessity: This regulation is necessary to establish requirements and processes through which MHPs authorize payment for services, including requirements established in Title 42, CFR, Section 438.210 regarding authorization of services, which is incorporated by reference.

Subsection (a) is necessary to establish the MHP's authority to determine whether or not to require MHP payment authorization for the services covered by this subchapter. This option will permit MHPs flexibility in their dealings with providers and will also allow for varying authorization standards depending on service function or agreement with the provider.

Subsections (b) and (c) are necessary to establish the standards the MHP must follow for its authorization function. The Department has determined that the State's general standards for all the included categories of professionals provide the minimum competence required for performing the authorization function. The additional

standards in this section parallel the requirements applicable to psychiatric inpatient hospital services as provided in Section 1820.220, except for the types of personnel who may deny requests for payment authorization. For psychiatric inpatient hospital services, physicians and psychologists (at the MHP's discretion) must review and approve the denial of a request for MHP payment authorization. For other specialty mental health services, any licensed mental health professional or waivered/registered professional may approve or deny services, except that psychiatric technicians and licensed vocational nurses may only do so if the service is required to treat a beneficiary's urgent condition. The differing standards have been established to recognize the greater consequence of error to the provider when authorization of psychiatric inpatient hospital service is denied. MHP payment authorization request for psychiatric inpatient hospital services are almost always submitted after the beneficiary has already been admitted for care, putting the provider at substantial financial risk if the request is denied. The rates for hospitalization are also significantly higher than for other services. Authorization of other specialty mental health services is likely to occur in advance of service delivery and rates are considerably lower. The more flexible standard for these services allows the MHP to use its professional resources, particularly physician resources, cost effectively.

Subsection (d) is necessary to clarify that the MHP may require MHP payment authorization in advance of the delivery of the service for any specialty mental health service other than emergency services. The MHP must have the flexibility to determine when prior authorization will be required as an essential element of the MHP's responsibility under this chapter to manage the mental health care of beneficiaries. The prohibition against prior authorization of emergency services is consistent with Medi-Cal law and the conditions of the approved federal waiver for the program.

Subsection (e) is necessary to implement requirements of Welfare and Institutions Code, Section 14043 et seq. to prevent potential fraud and abuse in the provision of day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services. Subsection (e) establishes the Department's authority to establish MHP contract obligations for MHP payment authorization of day treatment intensive, day rehabilitation, and EPSDT supplemental specialty mental health services, all of which are important EPSDT benefits.

As a result of the audits and reviews conducted by the Department in 2002 and 2003, the Department determined that day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services have been particularly vulnerable to inappropriate claiming. Requiring MHP payment authorization prevents potential fraud and abuse by requiring reviews of providers' determinations of medical necessity and request for services, including the type, amount and duration of requested services. Subsection (e) is also necessary to implement, in part, Section 5767 of the Welfare and Institutions Code, which requires the Department to strengthen and ensure statewide application of managed care principles, building on existing county systems, to manage the Medi-Cal EPSDT benefit while ensuring access to eligible Medi-Cal recipients.

The Department determined the MHP payment authorization system to be a crucial managed care principle and tool, since effective utilization control is one of the most

effective options available to managed care plans to provide medically necessary services while managing the cost of care. This position is supported by Title 42, CFR, Section 210, which provides specific requirements for managed care plan authorization systems. In addition, all MHPs have existing MHP payment authorization systems that address, at a minimum, psychiatric inpatient hospital services.

Subsection (f) is necessary to require the MHP to follow specific MHP payment authorization requirements for psychiatric inpatient hospital professional services, psychiatric health facilities, and psychiatric nursing facility services.

Subsection (g) is necessary to establish the MHP's authority to require providers to notify the MHP prior to the delivery of services, except in an emergency. This notification allows the MHP prior knowledge of its potential responsibility to pay for services and may provide opportunities to intervene appropriately in the treatment process without the more formal process of prior authorization of services. Since this provision may affect providers who do not have contractual agreements with the MHP and, therefore, may not otherwise be aware of the requirement, the MHP is required to provide general notice to providers. The most likely method for providing this notice would be through the Medi-Cal provider manuals published by the State Department of Health Services.

Subsection (g)(1) is necessary to establish the conditions under which late MHP payment authorization requests must be considered by the MHP and to provide authority for the MHP to determine other acceptable reasons for late submission of payment authorization requests. Subsection (g)(1)(A) is necessary to identify acceptable reasons for late submission and specify the necessary documentation from hospitals if any of these exceptions are claimed. Subsection (c)(1)(B) is necessary to identify reasons or justifications that would not excuse an untimely submission. The timelines established in this regulation are consistent with similar provisions for late submissions established for the regular Medi-Cal program and for late submissions of MHP payment authorization requests for psychiatric inpatient hospital services as provided in Section 1820.215.

Section 1830.220. Authorization of Out-of-Plan Services.

Specific Purpose: Section 1830.220 provides standards governing the situations in which the MHP must authorize services delivered for a beneficiary by out-of-plan providers.

Rationale for Necessity: This regulation is necessary to establish the limits of the authority of the MHP to restrict the beneficiary to receiving specialty mental health services only from the MHP or from a provider contracting with the MHP in specific circumstances.

Subsection (a) defines the term "out-of-plan services" to simplify the substantive text of the section.

Subsection (b) explains the circumstances under which an MHP must provide out-of-plan services when the MHP provides the same services directly or through MHP contractors.

Subsections (b)(1) and (2) identify that MHPs must authorize and pay for services provided to a beneficiary with an emergency psychiatric condition by providers who do not have a formal relationship with the MHP, either as contractors or employees of the MHP. Other sections of this chapter that provide more detail on the MHPs' obligations are cross-referenced. The provisions are included here for the sake of completeness.

Subsection (b)(3) is necessary to clarify the MHP's responsibility to provide timely access to services for a beneficiary with an urgent condition. This provision will ensure that the needs of the beneficiary will be considered first when the MHP is determining whether to authorize a non-contract provider to deliver a service to the beneficiary or to arrange for the beneficiary to see a contract provider.

Subsection (b)(4) is necessary to establish the MHP of the beneficiary's responsibility to arrange and pay for all covered, medically necessary specialty mental health services for beneficiaries who are placed in another county as a result of legal actions, primarily foster care placements and placements as a result of decisions by the legal conservators or guardians of the beneficiary.

Section 1830.225. Initial Selection and Change of Person Providing Services.

Specific Purpose: Section 1830.225 establishes the minimum standards governing beneficiaries' ability to choose the person within the MHP's provider network who will provide specialty mental health services to that beneficiary.

Rationale for Necessity: Subsection (a) is necessary to establish the MHP's responsibility to provide beneficiaries an initial choice of the person who will provide the beneficiary with specified outpatient specialty mental health services. This subsection allows the MHP to determine the initial assignment of the beneficiary to a group or organizational provider, and then to offer the beneficiary a choice of two of the persons affiliated with that provider, or to offer the beneficiary a choice of individual providers. This obligation on the part of the MHP would not apply if such a choice were not feasible, for example, if only one person had the capacity to accept an additional client. This subsection does not prevent the MHP from offering a wider choice to beneficiaries, if the MHP chooses to do so. The services for which a choice is required include the services that are most likely to provide for an ongoing relationship with a specific person providing the services. Inpatient hospital and nursing facility services are excluded, as are facility based outpatient services such as day treatment intensive and day rehabilitation.

Subsection (b) is necessary to establish the MHP's responsibility to provide beneficiaries an opportunity to request a change in the person providing services. The rationale is essentially the same as the rationale for the initial choice of provider, except that the MHP is required to offer the beneficiary one person as an alternative. A separate subsection was established for the sake of clarity.

Section 1830.230. Psychiatric Inpatient Hospital Professional Services.

Specific Purpose: Section 1830.230 establishes that the medical necessity criteria applicable to professional services provided to beneficiaries while the beneficiary is receiving psychiatric inpatient hospital services are the same criteria applicable to the psychiatric inpatient hospital services and that the MHP has limited authority to prior authorize these professional services.

Rationale for Necessity: Subsection (a) is necessary to establish that the medical necessity criteria for professional services performed in an inpatient hospital setting are the same as those specified in Section 1820.205 of this chapter, which governs the medical necessity for psychiatric inpatient hospital services. The subsection ensures that confusion over the differences between the medical necessity criteria for most services covered by this subchapter and the criteria for psychiatric inpatient hospital professional services will not result in any reduction of professional services for a beneficiary who is hospitalized.

Subsection (b) is necessary to clarify the authorization criteria for professional services performed in a Fee-for-Service/Medi-Cal hospital. These criteria limit professional services that are not subject to prior authorization to one service for each day the beneficiary is receiving acute psychiatric inpatient hospital services, consistent with current practice. An exception is made to allow two services to be delivered without prior authorization on the day of admission, when the admitting provider is not a physician, to allow for appropriate medication review. This subsection ensures that an acceptable level of professional services will be available when a beneficiary is hospitalized, while allowing the MHP to manage its responsibility for any additional professional services through an authorization process. The criteria are not applicable to Short-Doyle/Medi-Cal hospitals because the per diem rate to these hospitals includes professional services and, therefore, the authorization process for the hospital stay includes authorization of the professional services.

Section 1830.245. Psychiatric Health Facility Services.

Specific Purpose: Section 1830.245 establishes that the medical necessity criteria applicable to psychiatric health facility services is the same criteria applicable to the psychiatric inpatient hospital services and establishes MHP payment authorization processes applicable to psychiatric health facility services provided to beneficiaries in an emergency.

Rationale for Necessity: Subsection (a) is necessary to establish that the medical necessity criteria for psychiatric health facility services are the same as those specified in Section 1820.205 of this chapter, which governs the medical necessity for psychiatric inpatient hospital services, because psychiatric health facility services involve admission to a 24 hour care facility and are designed to provide essentially the same specialty mental health treatment component as psychiatric inpatient hospital services.

Subsection (b) is necessary to establish that the MHP may not require prior authorization of psychiatric health services when the beneficiary has an emergency

psychiatric condition, consistent with the requirements applicable to other similar specialty mental health services.

Subsection (c) is necessary to establish the MHP's authority to establish authorization procedures for psychiatric health facility services in the contract between the MHP and the facility. This provision also allows for authorization procedures to be governed by the contract between another MHP and the facility to accommodate the Department's understanding that some MHPs intend to establish procedures in their contracts with psychiatric health facilities that apply when the facility provides services to the beneficiary from another MHP. The subsection also provides requirements for MHP payment authorization of psychiatric health facility services for a beneficiary with an emergency psychiatric condition in the absence of any applicable contract. These requirements have been modeled on the requirements applicable to emergency admissions to psychiatric health facility services as described in Sections 1820.220 and 1820.225. This subsection does not govern the MHP's options for authorizing planned admissions for psychiatric health facility services. In these cases, Section 1830.215 will apply.

Section 1830.250. MHP Payment Authorization for Psychiatric Nursing Facility Services by a Point of Authorization.

Specific Purpose: Section 1830.250 establishes the MHP's responsibility to provide MHP payment authorization of psychiatric nursing facility services through the MHP's point of authorization in accordance with specific timelines and procedures that would apply if psychiatric nursing facility services are covered by the MHPs (see the rationale for Section 1810.345(d) for information on the status of coverage).

Rationale for Necessity: Subsection (a)(1) is necessary to establish an exception to the MHP's normal authority to limit services to contract providers for psychiatric nursing facility services. The Department has determined that it is necessary to encourage participation in the Medi-Cal Specialty Mental Health Services program by all of the nursing facilities currently providing the equivalent of psychiatric nursing facility services to Medi-Cal beneficiaries through the regular Medi-Cal program. There have been less than 35 facilities statewide that are licensed and certified to provide these services. The obligation to contract with up to 58 MHPs would be a significant administrative burden to an individual facility and could discourage participation.

Subsection (a)(2) is necessary to establish that the nursing facility must submit claims for psychiatric nursing facility services through the fiscal intermediary. This provision is also intended to encourage participation by nursing facilities. The facilities will experience minimal change to current claims processing procedures.

Subsections (b) and (c) are necessary to establish the MHP payment authorization procedures that must be followed by both the nursing facility and the MHP to ensure proper delivery of and payment for services. The procedures are modeled on the procedures for planned admissions to psychiatric inpatient hospital services as described in Sections 1820.215 and 1820.220.

Subsection (d) is necessary to establish that the MHP payment authorization request must be submitted using a Treatment Authorization Request, which is also required for psychiatric inpatient hospital services provided in Fee-for-Service/Medi-Cal hospitals, to accommodate provider billing through the fiscal intermediary.

Subsection (e) is necessary to describe the manner in which the MHP Point of Authorization must document approval or disapproval of a request for payment authorization.

Subsection (f) is necessary to provide timeframes and procedures for actions by the MHP regarding a request for MHP payment authorization. The Department determined that three days is an appropriate time frame because three working days corresponds with the minimum federal requirements as identified in Title 43, CFR, Section 438.210.

Subsection (g) is necessary to provide the criteria by which an MHP will approve payment authorization. To assure equity for beneficiaries and providers, conditions for approval must be clearly stated so that they can be consistently applied. Subsection (g)(1) clarifies that medical necessity must be documented and that other applicable requirements of the chapter must be met. Subsection (g)(2) established that approved MHP payment authorizations continue to be valid when the beneficiary is hospitalized or on leave of absence from the facility under the conditions established in regulations governing the regular Medi-Cal program and cross referenced here. Subsection (g)(3) clarifies that MHP payment authorization must be approved by the MHP in circumstances requiring medical assistance pending a fair hearing decision regardless of the MHP's determination of medical necessity.

Subsection (h) is necessary to establish that the MHP approving an MHP payment authorization request has assumed financial responsibility for the service, whether or not the MHP is the MHP of the beneficiary, unless a different decision is made as a part of a formal dispute resolution process. This provision is intended to minimize disputes between MHPs and between MHPs and providers over payment under these circumstances.

Subchapter 4. Federal Financial Participation

Article 1. General

Section 1840.100. Definitions.

Specific Purpose: Section 1840.100 identifies the specific meanings of terms in this subchapter.

Rationale for Necessity: Subsection (a) is necessary to clarify that the term "claiming" has a specific meaning in the context of this subchapter, which is more limited than the general usage of the term.

Subsection (b) is necessary to identify specific coding systems that may be used in the claiming process.

Subsection (c) is necessary to clarify that the term “legal entity” has a specific meaning in the context of this subchapter, which is more limited than the general usage of the term.

Subsection (d) is necessary to define the term “lockout,” which is commonly used within the Medi-Cal program that may or may not be well understood.

Subsection (e) is necessary to clarify that the term “reimbursement” has a specific meaning in the context of this subchapter, which is more limited than the general usage of the term

Subsection (f) is necessary to provide a single term, “service functions,” for use in this subchapter to refer to the coding system used to report services through the Short-Doyle/Medi-Cal claiming system.

Subsection (g) is necessary to distinguish the term “Short Doyle/Medi-Cal system” from the Fee-for-Service/Medi-Cal service system, which has a different mechanism for claiming FFP. The term selected is familiar to MHPs and to the State Department of Health Services, which have primary responsibility for administering the system.

Section 1840.105. General.

Specific Purpose: This section establishes the general basis for determining the FFP to which the MHP is entitled for specialty mental health services provided to beneficiaries under this chapter.

Rationale for Necessity: This section is necessary to ensure that reimbursement of FFP under the Medi-Cal Specialty Mental Health Services program is consistent with the Medi-Cal State Plan, thereby ensuring continuation of FFP for the specialty mental health services covered by MHPs.

Subsections (a)(1)-(4) are based on Title 22, Section 51516, which governs the provision of specific specialty mental health services when they are provided through the regular Medi-Cal program, rather than through MHPs operating under this chapter and the approved federal waiver. This section differs from Title 22, Section 51516, to the extent necessary to accommodate the additional services and provider types included under this chapter. Subsection (a)(4) includes maximum allowances by service function through a cross-reference to Title 22, Section 51516, to avoid unnecessary duplication. The maximum allowances under this chapter must be the same as those in Title 22, Section 51516, to ensure compliance with the Medi-Cal State Plan. Subsection (a)(4) provides an appropriate linkage for terms used in Title 22, Section 51516, that are not used in this chapter.

Subsection (b) specifies the CMS requirement governing the distribution of excess federal funds that exceed actual costs in the aggregate and are within maximum allowed limits, to the MHP, Short-Doyle/Medi-Cal hospitals, or organizational providers. This subsection is necessary because it protects the Department against distributing

funds that exceed actual costs in the aggregate, including the federal reimbursement and all state general funds that exceed the established maximum allowances as referenced in Subsection (a)(4).

Subsection (c) provides the single term “crisis stabilization” to include services provided in more than one type of facility. In Title 22, Section 51516, the terms “crisis stabilization-emergency room” and “crisis stabilization-urgent care” are used. A single term was used in this chapter to prevent confusion with other, more essential uses of the terms “emergency” and “urgent” in this chapter.

Section 1840.110. Claims Submission.

Specific Purpose: Section 1840.110 establishes the basic process by which MHPs will submit claims for payment of FFP to the State.

Rationale for Necessity: This section is necessary to establish that the Short-Doyle/Medi-Cal system will be used to claim FFP for most specialty mental health services and to set timelines for claim submission consistent with state and federal requirements. This section is essentially the same as Title 22, Section 51490, but is included here for the sake of completeness and to identify the specific exceptions to these requirements. The applicable exceptions are psychiatric inpatient hospital services provided in Fee-for-Service/Medi-Cal hospitals and psychiatric nursing facility services. This section cites Title 22, Section 51008.5, as the reference for good cause for exceptions to the six month time limit for submission of claims, rather than Title 22, Section 51008, which is cited in Title 22, Section 51490, because Section 51008.5 addresses good cause reasons more directly.

Section 1840.112. MHP Claims Certification and Program Integrity.

Specific Purpose: Section 1840.112 implements the requirements of Section 14043 et seq., of the Welfare and Institutions Code to prevent potential provider fraud and abuse by establishing MHP requirements for certification of claims and program integrity, including those established in Title 42, CFR, Part 438. Compliance with these requirements is necessary before MHPs may receive reimbursement of federal funds.

Rationale for Necessity: Subsection (a) prevents potential provider fraud and abuse by making the MHPs' overall responsibility for certification of claims and program integrity clear to MHPs and their providers. With the exception of the obligations under Title 42, CFR, Section 438.608, this subsection reflects current obligations of MHPs, not new policy or obligations. Significant state laws and federal regulations related to the certification of claims are included to ensure the MHPs and the public have a clear idea of the scope of the MHPs' responsibilities for certification of claims. This subsection also provides a context for the new requirements established by subsection (b).

Subsection (a) requires MHPs to comply with Title 42, CFR, Sections 438.604 and 438.606. Title 42, CFR, Section 438.604 requires that managed care plans certify the accuracy, completeness and truthfulness of data and documents submitted to the State for the claiming of federal financial participation, including enrollment information,

encounter data, and other information required by the State and contained in managed care plan contracts, proposals, and related documents. Title 42, CFR, Section 438.606 specifies that these data must be certified by the managed care plan's Chief Executive Officer, Chief Financial Officer, or an individual with delegated authority. The Department currently requires that MHPs' certification of claims for federal funds meet these requirements.

Subsection (a) requires that MHPs comply with the specific requirements of Title 42, CFR, Section 438.608, pertaining to program integrity. Title 42, CFR, Section 438.608 requires that MHPs must: a) develop a mandatory compliance plan designed to guard against fraud and abuse; b) develop written policies, procedures, and standards of conduct that articulate the county's commitment to comply with applicable federal and state standards; c) designate a compliance officer and compliance committee; d) conduct effective training and education for, and establish lines of communication between, the compliance officer and the organization's employees; e) enforce standards through well-publicized disciplinary guidelines; f) provide for internal monitoring and auditing; and g) provide for prompt response to detected offenses and development of corrective action initiatives relating to the MHP contract.

Subsection (b)(1) requires certification that clinical assessments comply with MHP contract requirements because assessments form the basis for building a comprehensive clinical picture of the beneficiary and for determining whether and what services are needed. The assessment process is critical in ensuring appropriate care and preventing over-utilization, including unnecessary services.

Subsection (b)(2) requires certification that the MHP has verified the client's Medi-Cal eligibility because the Department has determined that this is a key factor of false claims. Claims should not be submitted or paid for clients ineligible for services.

Subsection (b)(3) requires certification that the MHP has verified that the services for which federal financial participation is being claimed were delivered to the beneficiary. Otherwise, the claim should not be submitted or paid.

Subsection (b)(4) requires certification that medical necessity has been established for the services being delivered because medical necessity criteria are the key factors in determining whether or not a service is eligible for Medi-Cal reimbursement through the MHP. Claims should not be submitted or paid for services that are ineligible for reimbursement to the MHPs.

Subsection (b)(5) requires certification of the development and maintenance of client plans, because client plans form the basis for the initial and ongoing delivery of specific services that address the beneficiary's clinical needs and treatment goals. In addition to assessments and medical necessity determinations, client plans are critical to ensure that the type, level, amount and duration of services are appropriate.

Subsection (b)(6) requires certification that MHP payment authorizations for day treatment intensive, day rehabilitation and EPSDT supplemental specialty mental health services were conducted in accordance with MHP contract requirements in order to

ensure that claims are appropriate and conform to requirements contained in the MHP contracts.

Section 1840.115. Alternative Contract Provider Rates.

Specific Purpose: Section 1840.115 establishes the method by which the MHP must claim FFP for services provided under a contract with alternative rate provisions allowed under Section 1810.438.

Rationale for Necessity: This section is necessary to make it clear that MHPs that contract with providers on a basis other than fee-for-service must claim FFP for the specialty mental health services provided under the terms of that contract on a fee-for-service basis in accordance with the requirements of this subchapter applicable to the individual services.

Article 2. Psychiatric Inpatient Hospital Services

Section 1840.205. General.

Specific Purpose: Section 1840.205 identifies the FFP claiming systems to be used by the MHP when services are provided in Short-Doyle/Medi-Cal hospitals and Fee-for-Service/Medi-Cal hospitals.

Rationale for Necessity: This regulation is necessary to identify the claiming systems that will ensure the MHP receives appropriate reimbursement of FFP for psychiatric inpatient hospital services. The claiming systems are determined by the provider payment systems for the two types of hospitals established under subchapter 2, consistent with the approved federal waiver.

Section 1840.210. Non-Reimbursable Psychiatric Inpatient Hospital Services.

Specific Purpose: Section 1840.210 specifies that FFP is not available for beneficiaries of specified ages in hospitals that are psychiatric health facilities or acute psychiatric hospitals larger than 16 beds and that FFP is not claimable until a beneficiary has met his or her share of cost obligations under the Medi-Cal eligibility determination process.

Rationale for Necessity: This regulation is necessary to be consistent with federal regulations regarding FFP.

Section 1840.215. Lockouts for Psychiatric Inpatient Hospital Services.

Specific Purpose: Section 1840.215 identifies services that are not eligible for FFP if a beneficiary has received psychiatric inpatient hospital services on the same day.

Rationale for Necessity: This regulation is necessary to eliminate duplicate claiming of FFP.

Subsection (a) is necessary to list the specialty mental health services that are either included in the rate paid to the hospital for the psychiatric inpatient hospital service on that day or could not reasonably be provided to a beneficiary on the same day without duplication. This must be understood so that inaccurate or duplicate billings for mutually exclusive services do not occur.

Subsection (b) is necessary to except those situations included in this chapter in which a nursing facility may be entitled to payment for a psychiatric nursing facility service at a reduced rate while the beneficiary is receiving psychiatric inpatient hospital services.

Subsection (c) is necessary to identify additional locked out services for Short-Doyle/Medi-Cal hospitals beyond those itemized in subsection (a), based on the additional services included in the rate paid to Short-Doyle/Medi-Cal hospitals.

Article 3. Specialty Mental health Services Other than Psychiatric Inpatient Hospital Services

Section 1840.302 Psychiatric Nursing Facility Services.

Specific Purpose: Section 1840.302 specifies the manner in which FFP will be claimed for psychiatric nursing facility services.

Rationale for Necessity: This regulation is necessary to identify the claiming systems that will ensure the MHP receives appropriate reimbursement of FFP for psychiatric nursing facility services. The claiming system is determined by the provider payment system (i.e., the fiscal intermediary) for nursing facilities established under subchapter 3, consistent with the approved federal waiver.

Section 1840.304. Crosswalk between Service Functions and HCPCS Codes.

Specific Purpose: Section 1840.304 provides MHPs with a methodology to translate billing information from providers using the HCPCS codes into the service functions that must be used by the MHP to claim FFP through the Short-Doyle/Medi-Cal system.

Rationale for Necessity: This regulation is necessary to identify how MHPs will claim FFP for services when a provider bills the MHP based on HCPCS codes. Most providers, including those participating in the regular Medi-Cal program, bill for services using HCPCS codes. The crosswalk standardizes the service function and units of time for each code covered by the MHP providing statewide consistency. The option for the MHP to use the crosswalk for its contract providers, rather than requiring the provider to learn to bill using services functions and units of time allows MHPs to minimize change for these providers, removing a possible barrier for providers to participate in the program implemented by this chapter. Barriers to provider participation could have a negative impact on beneficiary access. The crosswalk also accommodates providers of psychiatric inpatient hospital professional services who do not have a contract with the MHP and who render these services to a beneficiary with an emergency psychiatric condition. These providers are unlikely to be familiar with or willing to bill using service functions and units of time.

Subsection (a) is necessary to provide the format for claiming FFP by the MHP for paid claims by individual and group providers for certain specialty mental health services. The Department will provide the specific comparative table (crosswalk) of service function and allowable codes to all MHPs through the contract between the Department and the MHP, rather than by regulation, because the HCPCS codes are subject to frequent changes that are outside the control of the Department.

Subsection (b) is necessary to explain to MHPs that when a provider has billed using a code not listed in the crosswalk, the sections governing claiming FFP for service functions must be fully applied, except for specific hospital outpatient department room-use codes. The FFP for these codes must be claimed in conjunction with the applicable specialty mental health services to ensure the integrity of claims data for oversight purposes.

Subsection (c) is necessary to clarify that the HCPCS codes as provided by the Department to the MHPs may be billed by any individual and group providers for specialty mental health services provided within their scope of practice.

Subsection (d) is necessary to explain that lockouts as described in Section 1840.215 and 1840.360 through 1840.374 apply to FFP claimed through the crosswalk and that the service function listed in the crosswalk provided by the Department determines the services that cannot be provided concurrently.

Subsection (e) is necessary to explain that the crosswalk provided by the Department is not to be used to claim FFP for services provided by organizational providers.

Section 1840.306. Psychiatrist, Psychologist, and EPSDT Supplemental Specialty Mental Health Services.

Specific Purpose: Section 1840.306 specifies the manner in which FFP will be claimed for psychiatrist, psychologist, and EPSDT supplemental specialty mental health services.

Rationale for Necessity: This regulation is necessary to identify the Short-Doyle/Medi-Cal system as the system under which the MHP will receive reimbursement of FFP for the identified services, in accordance with the crosswalk identified in Section 1840.304 and consistent with the approved federal waiver, unless a contractual agreement between the provider and the MHP states that FFP shall be claimed through procedures applicable to service functions.

Section 1840.308. Service Functions.

Specific Purpose: Section 1840.308 specifies the manner in which FFP will be claimed for service functions.

Rationale for Necessity: This section is necessary to identify the Short-Doyle/Medi-Cal system as the system under which the MHP will receive reimbursement of FFP for

the identified services, consistent with the approved federal waiver. This section also establishes that services billed to the MHP by providers as service functions, rather than as psychiatrist, psychologist, and EPSDT supplemental mental health services using the crosswalk identified in Section 1840.304, must be provided in accordance with specified requirements identified by cross references to Section 1840.314 through 1840.372. The requirements in these sections, which are modeled on the process used to claim FFP for Short-Doyle/Medi-Cal services under the regular Medi-Cal program, ensure that standardized information on the types and units of service provided are available for the determination of statewide maximum allowances and for the cost reporting system that determines the final amount of FFP to which the MHP is entitled, as described in Section 1840.105. The rationales for the individual requirements are discussed under the statement of reasons for the specific section. It is important to note that while these regulations are directed specifically at MHPs with regard to their ability to claim FFP for services, they also apply indirectly to individual, group and organizational providers that bill the MHP for the specialty mental health services using the service function system.

Section 1840.312. Non-Reimbursable Services-General.

Specific Purpose: Section 1840.312 specifies services that are not eligible for FFP either because they are not eligible for FFP under the Medi-Cal program or because the MHP is not responsible for the service under this chapter.

Rationale for Necessity: This regulation is necessary so that MHPs clearly understand which services are eligible for FFP. The services identified in subsections (a) through (e) are not eligible for reimbursement under the Medi-Cal program because they are not medical services. Subsection (f) references the section in this chapter that describes the services that are not covered by the MHP. Subsections (g) through (h) describe services that are not eligible for FFP based on federal restrictions of FFP for services provided to most beneficiaries under age 65 who reside in institutions for mental diseases. Subsections (g) and (h) also include specific situations in which FFP may be available for services provided to beneficiaries under age 21 and beneficiaries who are between 21 and 22 years of age residing in institutions for mental diseases. The possibility of an exception is specified in subsection (i), because the Department understands some consideration has been given to changes in federal law on this issue, and because these services may be eligible for FFP under federal waivers if the State establishes that covering the services is cost effective. Subsection (j) describes those specialty mental health services that are not eligible for FFP because they are provided to a minor whose eligibility for Medi-Cal services is based on state law rather than federal eligibility requirements. Except for the actual bed and care charges for the institution for mental disease, the services described in subsections (g) through (j) are covered by the MHP when they meet the requirements of Section 1810.345. Subsection (k) provides that an MHP may not claim FFP until the beneficiary has met his or her share of cost obligations under the Medi-Cal eligibility determination process.

Section 1840.314. Claiming for Service Functions-General.

Specific Purpose: Section 1840.314 specifies reimbursement rules that apply to claiming FFP for any service function.

Rationale for Necessity: This regulation is necessary so that MHPs clearly understand what conditions must be met for a service function to be eligible for FFP. Subsection (a) makes it clear that the service must be provided to a beneficiary by a provider eligible under the federal and state law to deliver the service. The provider of a service must be eligible to participate in the Medi-Cal program for the MHP to be eligible to claim FFP for a service delivered by that provider. Medi-Cal standards generally require that a provider is appropriately licensed, registered or certified to provide the service and has not been convicted of Medicaid or Medicare fraud. Providers contracting with the MHP will typically meet higher standards (see Section 1810.435), but MHPs are required in some circumstances to use out-of-plan providers to deliver some services under this chapter (see Section 1830.220).

Subsection (b) clarifies that services provided to significant support persons must be directed exclusively to the mental health needs of the beneficiary to qualify for FFP, since only the beneficiary is eligible under the Medi-Cal program.

Subsection (c) clarifies that clear documentation is required when two or more persons deliver services to a beneficiary at one time.

Subsection (d) clarifies that, to be eligible for FFP, services must be within the scope of practice of the person delivering services, when professional licensure is required for the service.

Subsection (e) is necessary to explain that, to be eligible for FFP, specialty mental health services must be provided under the direction of individuals with specific qualifications. The subsection includes a definition of what "under the direction of" means.

Subsection (f) is necessary to clarify that, to be eligible for FFP, services provided by hospital outpatient departments must be within the scope of the facility's licensure.

Section 1840.316. Claiming for Service Functions Based on Minutes of Time.

Specific Purpose: Section 1840.316 specifies reimbursement rules that apply to claiming FFP for service functions that are reimbursed based on minutes of time.

Rationale for Necessity: Subsection (a) is necessary to identify the service functions that are reimbursed based on the time of the person delivering the service in minutes of time, consistent with Medi-Cal State Plan, "Reimbursement For Short-Doyle/Medi-Cal: Attachment 4.19-B: Outpatient, Rehabilitative, Case Management and Other Services" (Pages 21-25), TN 93-009, approved July 22, 1994, effective July 1, 1993.

Subsection (b)(1) is necessary to provide a clear requirement to prevent billing of a greater amount of time than the number of minutes in an hour, or a greater amount of time than worked by a staff person in a given day.

Subsection (b)(2) is necessary so that the MHPs and providers will clearly understand how to calculate reimbursable staff time for services provided to more than one beneficiary. It is possible that services will be billed and paid based on inappropriate calculations of staff time if this is not clearly stated in the regulation.

Subsection (b)(3) is necessary to clarify under what circumstance the staff time required for documentation is reimbursable. If not stated in these regulations, it is likely that MHPs and providers will not clearly understand when and how documentation and travel are reimbursable.

Subsection (b)(4) is necessary to clarify that plan development is reimbursable, even without a contact or unit of service provided to the beneficiary in person. This subsection allows for more effective use of the time a person providing services spends with the beneficiary, without jeopardizing necessary planning because of inadequate reimbursement.

Section 1840.318. Claiming for Service Functions Based on Half Days or Full Days of Time.

Specific Purpose: Section 1840.318 specifies reimbursement rules that apply to claiming FFP for service functions that are reimbursed based on half days or full days of service to the beneficiary.

Rationale for Necessity: Subsection (a) is necessary to identify the service functions that are reimbursed based on half day or full day of time, consistent with the Medi-Cal State Plan.

Subsection (b)(1) is necessary to clarify the billing requirements when a beneficiary receives a half-day of Day Treatment Intensive or Day Rehabilitation, including the minimum number of hours the services must be available. Four hours is half of the generally accepted eight-hour business day; less than three hours would not be considered day treatment by commonly accepted industry standards. It is possible that providers and MHPs will not understand these requirements if not specified in these regulations.

Subsection (b)(2) is necessary to clarify the billing requirements when a beneficiary receives a full day of Day Treatment Intensive or Day Rehabilitation, and to identify the minimum number of hours that distinguishes full day from half day. More than four hours was set as a full day to prevent a gap between half days and full days.

Subsection (b)(3) is necessary to explain that, while there must be face-to-face contact with the beneficiary for any day treatment intensive or day rehabilitation service claimed, all services claimed on the day of service need not be face-to-face with the beneficiary.

For example, plan development is an allowable service activity for which the beneficiary need not always be present.

Section 1840.320. Claiming for Service Functions Based on Calendar Days.

Specific Purpose: Section 1840.320 specifies reimbursement rules that apply to claiming FFP for service functions that are reimbursed based on calendar days of service to the beneficiary.

Rationale for Necessity: Subsection (a) is necessary to identify the service functions that are reimbursed based on calendar days, consistent with the Medi-Cal State Plan, "Reimbursement For Short-Doyle/Medi-Cal: Attachment 4.19-B: Outpatient, Rehabilitative, Case Management and Other Services" (Pages 21-25), TN 93-009, approved July 22, 1994, effective July 1, 1993.

Subsection (b)(1) is necessary to clarify the circumstances under which a calendar day of services may be reimbursed. Clarifying that the beneficiary must receive face-to-face services and be admitted to the program is likely to reduce the possibility of inappropriate claiming of FFP.

Subsection (b)(2) is necessary to clarify that board and care costs are not included in the claiming rate, to ensure consistency with federal requirements and Medi-Cal State Plan requirements, and to reduce to possibility of inappropriate claiming of FFP.

Subsection (b)(3) is necessary to establish that the standard billing practice in the health care industry and applicable to the Medi-Cal program that the day of discharge is not billed applies to services that are reimbursed based on calendar days, to prevent inappropriate claiming of FFP.

Section 1840.322. Claiming for Service Functions Based on Hours of Time.

Specific Purpose: Section 1840.322 specifies reimbursement rules that apply to claiming FFP for service functions that are reimbursed based on hours of time spent with the beneficiary.

Rationale for Necessity: Subsection (a) is necessary to identify the service functions that are reimbursed based on hours of time, consistent with the Medi-Cal State Plan, "Reimbursement For Short-Doyle/Medi-Cal: Attachment 4.19-B: Outpatient, Rehabilitative, Case Management and Other Services" (Pages 21-25), TN 93-009, approved July 22, 1994, effective July 1, 1993.

Subsection (b)(1) is necessary to identify that hours are based on hour blocks of time a beneficiary receives services. Use of hour blocks of time for these services is the most appropriate claiming unit for this type of service due to the volume of services provided and the acuity of beneficiaries receiving services. Other possible claiming units considered were minutes of service and half days. Claiming by minutes would result in unreasonable documentation requirements, and half days would create an inaccurate

reflection of the actual service time provided, and the result in claiming of FFP that is not commensurate with services provided.

Subsection (b)(2) is necessary to clarify the claiming practice for rounding of partial hours into one hour blocks. To have the amount claimed reflect the amount of services received as accurately as possible, the amount claimed is to be rounded to the nearest increment. The exception to this rule is the rounding upward of the first hour, so that the provision of a service will always result in the ability to claim FFP, even if the time spent with the beneficiary is less than one hour.

Section 1840.324. Mental Health Services Contact and Site Requirements.

Specific Purpose: Section 1840.324 describes specific elements that must be present before the MHP may claim FFP for a mental health service.

Rationale for Necessity: This regulation is necessary to establish the types of contact the person providing the mental health service must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while providing flexibility to MHPs to deliver the services in ways that best meet the beneficiary's needs.

Section 1840.326. Medication Support Services Contact and Site Requirements.

Specific Purpose: Section 1840.326 describes specific elements that must be present before the MHP may claim FFP for a medication support service.

Rationale for Necessity: This regulation is necessary to establish the types of contact the person providing the medication support service must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while providing flexibility to MHPs to deliver the services in ways that best meet the beneficiary's needs. In addition, the regulation makes it clear that medication support services that are provided within a residential or day program may be claimed separately from the residential or day program service.

Section 1840.328. Day Treatment Intensive Services Contact and Site Requirements.

Specific Purpose: Section 1840.328 establishes that a specific site must be identified before the MHP may claim FFP for a day treatment intensive service.

Rationale for Necessity: This regulation is necessary to distinguish day treatment intensive services from other specialty mental health services in terms of the site at which the service is delivered to standardize services for claiming purposes. The regulation also makes clear that all services need not be delivered at the site.

Section 1840.330. Day Rehabilitation Services Contact and Site Requirements.

Specific Purpose: Section 1840.330 establishes that a specific site must be identified before the MHP may claim FFP for a day rehabilitation service.

Rationale for Necessity: This regulation is necessary to distinguish day rehabilitation services from other specialty mental health services in terms of the site at which the service is delivered to standardize services for claiming purposes. The regulation also makes clear that all services need not be delivered at the site.

Section 1840.332. Adult Residential Treatment Services Contact and Site Requirements.

Specific Purpose: Section 1840.332 describes specific elements that must be present before the MHP may claim FFP for an adult residential treatment service.

Rationale for Necessity: This regulation is necessary to distinguish adult residential treatment services from other specialty mental health services in terms of the site at which the service is delivered and to establish that there must be a face-to-face contact with the beneficiary to standardize services for claiming purposes. The regulation also makes clear that all services need not be delivered at the site. In addition, the regulation provides the certification and licensing requirements that must be met by the facilities providing these services to clarify the types of facilities included.

Section 1840.334. Crisis Residential Treatment Services Contact and Site Requirements.

Specific Purpose: Section 1840.334 describes specific elements that must be present before the MHP may claim FFP for a crisis residential treatment service.

Rationale for Necessity: This regulation is necessary to distinguish crisis residential treatment services from other specialty mental health services in terms of the site at which the service is delivered and to establish that there must be a face-to-face contact with the beneficiary to standardize services for claiming purposes. The regulation also makes clear that all services need not be delivered at the site. In addition, the regulation provides the certification and licensing requirements that must be met by the facilities providing these services to clarify the types of facilities included.

Section 1840.336. Crisis Intervention Contact and Site Requirements.

Specific Purpose: Section 1840.336 describes specific elements that must be present before the MHP may claim FFP for crisis intervention.

Rationale for Necessity: This regulation is necessary to establish the types of contact the person providing the crisis intervention must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while

providing flexibility to MHPs to deliver the services in ways that best meet the beneficiary's needs.

Section 1840.338. Crisis Stabilization Contact and Site Requirements.

Specific Purpose: Section 1840.338 describes specific elements that must be present before the MHP may claim FFP for crisis stabilization.

Rationale for Necessity: This regulation is necessary to distinguish crisis stabilization from other specialty mental health services in terms of the site at which the service is delivered, including the medical and assessment services that must be available at the site, to standardize services for claiming purposes.

Section 1840.340. Psychiatric Health Facility Services Contact and Site Requirements.

Specific Purpose: Section 1840.340 describes specific elements that must be present before the MHP may claim FFP for psychiatric health facility services.

Rationale for Necessity: This regulation is necessary to distinguish psychiatric health facility services from other specialty mental health services in terms of the site at which the service is delivered and to establish that there must be a face-to-face contact with the beneficiary to standardize services for claiming purposes. In addition, the regulation provides the certification and licensing requirements that must be met by the facilities providing these services to clarify the type of facilities included.

Section 1840.342. Targeted Case Management Contact and Site Requirements.

Specific Purpose: Section 1840.342 describes specific elements that must be present before the MHP may claim FFP for targeted case management services.

Rationale for Necessity: This regulation is necessary to establish the types of contact the person providing the targeted case management service must have with the beneficiary or a significant support person for the beneficiary and to establish the locations at which services may be delivered. This standardizes services for claiming purposes while providing flexibility to MHPs to deliver the services in ways that best meet the beneficiary's needs.

Section 1840.344. Service Function Staffing Requirements - General.

Specific Purpose: Section 1840.344 describes the general staffing requirement that must be met before the MHP may claim FFP for mental health services, day rehabilitation services, day treatment intensive services, crisis intervention, targeted case management services and adult residential treatment services.

Rationale for Necessity: This regulation is necessary to establish the MHP's general authority to determine who is qualified to provide specific specialty mental health services, as long as there is no violation of state laws governing scope of practice. This

section sets the basic standard, which is subject to specific limitations identified for individual services in the sections that follow.

Section 1840.346. Medication Support Service Staffing Requirements.

Specific Purpose: Section 1840.346 describes the specific staffing requirements that must be met before the MHP may claim FFP for medication support services.

Rationale for Necessity: This regulation is necessary to standardize medication support services in terms of the licensed or registered persons who may deliver the services for the purpose of claiming FFP consistent with appropriate scope of practice and client care.

Section 1840.348. Crisis Stabilization Staffing Requirements.

Specific Purpose: Section 1840.348 describes the specific staffing requirements that must be met before the MHP may claim FFP for crisis stabilization.

Rationale for Necessity: This regulation is necessary to standardize crisis stabilization services in terms of the persons who may deliver the services for the purpose of claiming FFP consistent with appropriate scope of practice and client care.

Section 1840.350. Day Treatment Intensive Staffing Requirements.

Specific Purpose: Section 1840.350 describes the specific staffing requirements that must be met before the MHP may claim FFP for day treatment intensive services.

Rationale for Necessity: This regulation is necessary to standardize day treatment intensive services in terms of the persons who may deliver the services for the purpose of claiming FFP consistent with appropriate scope of practice and client care. The regulation also describes how staff providing less than full day services shall be accounted for in the required ratio of staff to beneficiaries.

Section 1840.352. Day Rehabilitation Staffing Requirements.

Specific Purpose: Section 1840.352 describes the specific staffing requirements that must be met before the MHP may claim FFP for day rehabilitation services.

Rationale for Necessity: This regulation is necessary to standardize day rehabilitation services in terms of the persons who may deliver the services for the purpose of claiming FFP consistent with appropriate scope of practice and client care. The regulation also describes how staff providing less than full day services shall be accounted for in the required ratio of staff to beneficiaries.

Section 1840.354. Adult Residential Treatment Services Staffing Requirements.

Specific Purpose: Section 1840.354 describes the specific staffing requirements that must be met before the MHP may claim FFP for adult residential treatment services.

Rationale for Necessity: This regulation is necessary to standardize adult residential treatment services in terms of the persons who may deliver the services for the purpose of claiming FFP consistent with appropriate scope of practice and client care. The regulation incorporates by reference Title 9, CCR, Section 531, which includes staffing requirements from the certification standards for Social Rehabilitation Programs. All providers of Adult Residential Treatment Services must be certified as Social Rehabilitation Programs.

Section 1840.356. Crisis Residential Treatment Services Staffing Requirements.

Specific Purpose: Section 1840.356 describes the specific staffing requirements that must be met before the MHP may claim FFP for crisis residential treatment services.

Rationale for Necessity: This regulation is necessary to standardize crisis residential treatment services in terms of the persons who may deliver the services for the purpose of claiming FFP consistent with appropriate scope of practice and client care. The regulation incorporates by reference Title 9, CCR, Section 531, which includes staffing requirements from the certification standards for Social Rehabilitation Programs. All providers of Crisis Residential Treatment Services must be certified as Social Rehabilitation Programs.

Section 1840.358. Psychiatric Health Facility Staffing Requirements.

Specific Purpose: Section 1840.358 describes the specific staffing requirements that must be met before the MHP may claim FFP for psychiatric health facility services.

Rationale for Necessity: This regulation is necessary to standardize psychiatric health facility services in terms of the persons who may deliver the services for the purpose of claiming FFP consistent with staffing standards required as condition of licensure as a psychiatric health facility.

Section 1840.360. Lockouts for Day Rehabilitation and Day Treatment Intensive Services.

Specific Purpose: Section 1840.360 establishes that the MHP may not claim FFP for day rehabilitation or day treatment intensive services if specified specialty mental health services are claimed for the same day.

Rationale for Necessity: This regulation is necessary to eliminate duplicate claiming of FFP.

Section 1840.362. Lockouts for Adult Residential Treatment Services.

Specific Purpose: Section 1840.362 establishes that the MHP may not claim FFP for adult residential treatment services if specified specialty mental health services are claimed for the same day.

Rationale for Necessity: This regulation is necessary to eliminate duplicate claiming of FFP.

Section 1840.364. Lockouts for Crisis Residential Treatment Services.

Specific Purpose: Section 1840.364 establishes that the MHP may not claim FFP for crisis residential treatment services if specified specialty mental health services are claimed for the same day.

Rationale for Necessity: This regulation is necessary to eliminate duplicate claiming of FFP.

Section 1840.366. Lockouts for Crisis Intervention.

Specific Purpose: Section 1840.366 establishes that the MHP may not claim FFP for crisis intervention if specified specialty mental health services are claimed for the same day.

Rationale for Necessity: Subsection (a) is necessary to eliminate duplicate claiming of FFP.

Subsection (b) is necessary to standardize the service for claiming purposes by distinguishing it from crisis stabilization. Allowing more than 8 hours of crisis intervention to be claimed in a 24-hour period is likely to result in inappropriate use of this service function.

Section 1840.368. Lockouts for Crisis Stabilization.

Specific Purpose: Section 1840.368 establishes that the MHP may not claim FFP for crisis stabilization if specified specialty mental health services are claimed for the same day and sets the maximum hours that may be claimed in a 24-hour period.

Rationale for Necessity: Subsections (a) and (b) are necessary to eliminate duplicate claiming of FFP.

Subsection (c) is necessary to standardize the service for claiming purposes by distinguishing it for 24-hour services such as psychiatric health facility services. Allowing more than 20 hours of crisis stabilization to be claimed in a 24-hour period is likely to result in inappropriate use of this service function.

Section 1840.370. Lockouts for Psychiatric Health Facility Services.

Specific Purpose: Section 1840.370 establishes that the MHP may not claim FFP for psychiatric health facility services if specified specialty mental health services are claimed for the same day.

Rationale for Necessity: This regulation is necessary to eliminate duplicate claiming of FFP.

Section 1840.372. Lockouts for Medication Support Services.

Specific Purpose: Section 1840.372 identifies the maximum number of hours in a 24-hour period for which the MHP may claim FFP for medication support services.

Rationale for Necessity: This regulation is necessary to standardize the service for claiming purposes by distinguishing it from other specialty mental health services that may appropriately require more time. The Department has determined that reimbursement of more than four hours of Medication Support Services in a 24-hour period is likely to result in inappropriate use of this service function.

Section 1840.374. Lockouts for Targeted Case Management Services.

Specific Purpose: Section 1840.374 establishes that the MHP may not claim FFP for targeted case management services if specified specialty mental health services are claimed for the same day.

Rationale for Necessity: Subsection (a) is necessary to eliminate duplicate claiming of FFP.

Subsection (b) is necessary to provide an exception to the lock outs described in subsection (a) to allow targeted case management services to be provided as part of discharge planning when a beneficiary has been admitted to a 24 hour facility. The Department has determined that allowing the services to be claimed if they are provided during the 30 days prior to discharge is adequate to arrange for appropriate services on discharge. The subsection also provides for situations in which the discharge does not occur as planned and new linkages must be established for the beneficiary.

Subchapter 5. Problem Resolution Processes

Article 1. Beneficiary Problem Resolution Process

Section 1850.205. General Provisions.

Specific Purpose: Section 1850.205 identifies the minimum required components of the beneficiary problem resolution processes required of the MHP for the purpose of a determination in cases of beneficiary disputes with providers and/or the MHP.

Rationale for Necessity: This regulation is necessary to provide beneficiaries with a grievance system consistent with the requirements of AB 757 (Chapter 633, Statutes of 1994) and Title 42, CFR, Part 438, Subpart F. This regulation specifies the minimum requirements imposed by the Department for the beneficiary problem resolution processes.

Subsection (a) is necessary to assure that each MHP shall develop a beneficiary problem resolution process and to clarify the issues covered by the process.

Subsection (b) is necessary to identify the basic components of the beneficiary problem resolution process to set the framework in this Section for the requirements that are common to all components and for the requirements of the specific components, which are provided in Sections 1850.206, 1850.207 and 1850.208.

Subsection (c) is necessary to explain what the MHP shall ensure are included in the grievance, appeal and expedited appeal processes.

Subsection (c)(1) is necessary to indicate that each beneficiary is entitled to specific information regarding the beneficiary problem resolution process. This includes the information that the beneficiary may request a State fair hearing at any time before, during or within 90 days after the completion of the beneficiary problem resolution process.

Subsections (c)(2)-(6) provide certain rights and protections of beneficiaries who utilize the beneficiary problem resolution process, including the MHP's responsibility to provide assistance to the beneficiary in writing the grievance, appeal or expedited appeal.

Subsection (c)(7) is necessary because it requires a procedure whereby issues identified in the grievance, appeal or expedited appeal processes are transmitted to the MHP's administration for consideration in light of changes that may be needed to the MHP's system.

Subsection (c)(8) and (9) are necessary to include requirements established in Title 42, CFR, Section 438.406 that contribute to the integrity of the beneficiary problem resolution process.

Subsection (d) is necessary to describe MHP requirements for processing and documentation on grievances, appeals and expedited appeals.

Subsections (d)(1)-(2) are necessary to describe the purpose and components of the grievance and appeal log and establish a timeframe for recording information in the log. One working day has been determined to be a reasonable timeframe for recording the initial grievance and appeal information to allow the MHP to track the grievance or appeal to ensure timely resolution. The one working day time balances MHP workload considerations with the need to ensure timely resolution of grievances and appeals. MHPs are required to record final disposition of the grievance or appeal in the log to provide a single source for reviews of the beneficiary problem resolution process by the Department and other oversight agencies. The requirement may also assist MHPs in preparing the annual grievance and appeal report required by Section 1810.375.

Subsections (d)(3)-(6) are necessary to ensure that the beneficiary and other appropriate persons are informed of the status of the grievance.

Subsection (e) is necessary to eliminate any confusion between beneficiary problem resolution processes of the MHP and existing activities and safeguards available through the provisions of the Welfare and Institutions Code pertaining to county patients' rights advocates.

Section 1850.206. The Grievance Process.

Specific Purpose: Section 1850.206 establishes the grievance process.

Rationale for Necessity: This Section is necessary to describe the nature and components of the grievance process.

Subsection (a) is necessary to clarify that grievances may be oral or in writing, consistent with Title 42, CFR, Section 438.402.

Subsection (b) establishes the time frames for issuance of a grievance decision, consistent with Title 42, CFR, Section 438.408. The federal rule allows the Department to establish the basic time frame provided it does not exceed 90 days. The Department has established a 60-day time frame as the most reasonable to allow for careful review of the issues and issuance of the decision by the MHP.

Subsection (c) establishes the MHP's responsibility to notify the beneficiary or the beneficiary's representative of the grievance decision. Timeframes are established based upon federal regulations in Title 42, CFR, Section 438.408, which provides for a 14-day extension process.

Section 1850.207. The Appeal Process

Specific Purpose: Section 1850.207 establishes the appeal process.

Rationale for Necessity: This Section is necessary to describe the nature and components of the appeal process.

Subsection (a) is necessary to clarify that an appeal may be filed orally or in writing, consistent with Title 42, CFR, Section 438.402.

Subsection (b) clarifies that an oral appeal must be followed-up with a signed, written appeal and that the date of the oral appeal is considered the filing date, consistent with Title 42, CFR, Section 438.402.

Subsection (c) sets forth the MHP timeline requirements for decisions and notifications on appeals, consistent with Title 42, CFR, Section 438.408.

Subsection (d) requires the MHP to inform beneficiaries that they may request a fair hearing at any time before, during or after the appeal process has begun. The Department has determined that allowing beneficiaries to proceed directly to fair hearing if they wish, rather than requiring exhaustion of the appeal process, will provide a better opportunity for resolving issues and that it is important that beneficiaries be reminded of the option at the time an appeal is filed.

Subsection (e) requires the MHPs to provide beneficiaries with a reasonable opportunity to present evidence and allegations of fact or law, in person or in writing, consistent with Title 42, CFR, Section 438.406.

Subsection (f) requires the MHPs to provide the beneficiary and/or his or her representative rights to examine the beneficiary's case file before and during the appeal process, consistent with Title 42, CFR, Section 438.406.

Subsection (g) requires the MHPs to allow the beneficiary and/or his or her representative, or the legal representative of a deceased beneficiary's estate to be included as parties to the appeal, consistent with Title 42, CFR, Section 438.406.

Subsection (h) requires notification of the beneficiary and/or his or her representative of the resolution of the appeal in writing and explains the required elements of the notification, consistent with Title 42, CFR, Section 438.408.

Subsection (i) established the MHP's responsibility to provide or arrange and pay for disputed services, consistent with Title 42, CFR, Section 438.424, where the resolution of an appeal reverses a decision to deny, limit or delay services.

Section 1850.208. The Expedited Appeal Process.

Specific Purpose: Section 1850.208 establishes the expedited appeal process in accordance with Title 42, CFR, Section 438.410.

Rationale for Necessity: This Section is necessary to describe the nature and components of the expedited appeal process, to clarify when the expedited appeal process is used instead of the appeal process, and to specify the additional requirements for expedited appeals from the appeal process established in Section 1850.207.

Subsection (a) establishes that an expedited appeal must be used when the MHP determines or the beneficiary and/or the beneficiary's provider certifies that taking the time allowed for resolution of an appeal pursuant to Section 1850.207 could seriously jeopardize the beneficiary's life, health or ability to attain, maintain, or regain maximum function.

Subsection (b) allows the beneficiary to file an oral request for an expedited appeal.

Subsection (c) requires that MHPs ensure that punitive action is not taken against a beneficiary or a provider because they request an expedited appeal or support a beneficiary's request for an expedited appeal.

Subsection (d) requires MHPs to provide written notice of the appeal and make reasonable efforts to resolve an expedited appeal and notify the affected parties in writing, no later than three working days after the MHP receives the appeal, and provides for extensions as specified. The timeframes are consistent with the minimum timeframes established by Title 42, CFR, Section 438.408(b)(3) and (c).

Subsection (e) provides that MHPs must give beneficiaries a written notice of the expedited appeal disposition and make reasonable efforts to provide oral notice to the

beneficiary and/or his or her representative. The written notice must meet the requirements of Section 1850.207(h).

Subsection (f) establishes MHP requirements where requests for expedited appeals are denied.

Section 1850.209. Beneficiary Problem Resolution Processes Established by Providers.

Specific Purpose: Section 1850.209 establishes the non-MHP provider beneficiary problem resolution processes.

Rationale for Necessity: This Section is necessary to clarify that problem resolution processes established by providers do not limit the beneficiary's access to the MHP's problem resolution processes unless there is a specific delegation of the function to the provider and the provider's process fully complies with this section.

Article 2. Fair Hearing and Notice of Action.

Section 1850.210. Providing a Notice of Action.

Specific Purpose: Section 1850.210 identifies key provisions regarding notices of action and incorporates by reference Title 22, Section 51014.1, which governs the notice of action requirements applicable to the Medi-Cal program as a whole.

Rationale for Necessity: This regulation is necessary to assure that the beneficiary is notified when action is taken by the MHP to deny, modify, or defer action on a request from a provider for a specialty mental health service in accordance with federal and State laws governing the Medi-Cal program. This section is based on the regulations in the regular Medi-Cal program that apply to Medi-Cal managed care plans, Title 22, Sections 51014.1 and 53261 and on the requirements of Title 42, CFR, Part 438, Subpart F.

Subsection (a) is necessary to explain the circumstances under which an MHP must provide a Notice of Action to a beneficiary when the MHP denies or modifies the provider's request for MHP payment authorization.

Subsection (a)(1) establishes those situations in which the MHP denies or modifies a request for authorization of continuing services are governed by Title 22, CCR, Section 51014.1. The Department has determined that where notice requirements have been established for the Medi-Cal program as a whole, these requirements should apply to this Chapter as well unless there is a conflict with the requirements of Title 42, CFR, Part 438, Subpart F.

Subsections (a)(2)-(4) are necessary to explain the circumstances under which a notice is not required by subsection (a). The situations in which notices are not required are situations in which there is no direct impact on a beneficiary's access to services that a provider believes are medically necessary.

Subsection (b) is necessary to require a Notice of Action when the MHP denies or modifies an MHP payment authorization request from a provider for a specialty mental health service that has already been provided to the beneficiary when the denial or modification is a result of post-service, prepayment determination by the MHP that the service was not medically necessary or otherwise was not a service covered by the MHP. This notice requirement is established to ensure that beneficiaries receive notice when federal law would allow a provider to bill a beneficiary for the services provided. State law at Section 14019.4 of the Welfare and Institutions Code does not permit providers to bill beneficiaries under these circumstances.

Subsection (c) requires that MHPs deny the authorization request and provide the beneficiary with a Notice of Action when the MHP does not have sufficient information to approve or modify an MHP payment authorization request from a provider within the timeframes required by Sections 1820.220 or 1830.215. This requirement is needed to comply with Title 42, CFR, Section 438.404.

Subsection (d) requires MHPs to provide Notices of Action to beneficiaries if the MHP fails to notify the affected parties of within the timeframes established for the issuance of grievance, appeal and expedited appeal decisions. This requirement is needed to comply with Title 42, CFR, Section 438.404.

Subsection (e) requires MHPs to provide Notices of Action to beneficiaries if the MHP fails to provide a specialty mental health service covered by the MHP within the timeframe for delivery of the service established by the MHP. This requirement is needed to comply with Title 42, CFR, Section 438.404.

Subsection (f)(1)–(4) clarifies that MHPs must comply with the requirements of Section 1850.212 regarding the content of Notices of Action and establishes the timeframes for mailing of Notices of Action. The established timeframes comply with the requirements of Title 42, CFR, Section 438.404.

Subsection (g) is necessary to comply with the condition of the Medi-Cal Specialty Mental Health Services Consolidation waiver renewal request approved by HCFA in September 1997, which requires that beneficiaries receive a notice of action, whether or not it would otherwise be required by this Section, when the MHP or its providers determine that a beneficiary would not be entitled to receive any specialty mental health services from the MHP. The Subsection establishes the MHP's responsibility to provide notice, describes the timing of the notice, and cites Section 1850.212 for the contents of the Notice of Action.

Subsection (h) is necessary to clarify that references to Medi-Cal managed care plans in Title 22, Section 51014.1, which is made applicable to MHPs by cross reference, mean the MHPs for the purposes of this Section.

Subsection (i) is necessary to clarify that the term "medical service" as used in Title 22, Section 51014.1, means specialty mental health services for the purposes of this section.

Subsection (j) is necessary to require MHPs to retain copies of all notices of action in a centralized location for the purpose of review by oversight agencies.

Section 1850.212. Contents of a Notice of Action.

Specific Purpose: Section 1850.213 identifies key provisions regarding the contents of the notice of action, including fair hearing information.

Rationale for Necessity: This Section is necessary to specify the content and format of the written Notice of Action pursuant to Section 1850.210.

Subsection (a) is necessary to specify the content of the Notice of Action pursuant to Section 1850.210(a), (c) or (d). This content is required when MHP payment authorization for a specialty mental health service is requested by a provider and denied, modified, terminated, reduced or deferred by the MHP.

Subsection (b) is necessary to specify the content of the Notice of Action pursuant to Section 1850.210(g). This content is required when an MHP or its providers determine that medical necessity criteria as specified in Sections 1830.205(b)(1), (2), (3)(C), or 1830.210(a) have not been met.

Section 1850.213. Fair Hearings.

Specific Purpose: Section 1850.213 identifies key provisions regarding fair hearings.

Rationale for Necessity: This Section is necessary to clarify that the State Department of Health Services will continue to be responsible for administering fair hearings for beneficiaries covered by MHPs.

Section 1850.215. Continuation of Services Pending Fair Hearing Decision.

Specific Purpose: Section 1850.215 incorporates by reference Title 22, Section 51014.2, which governs the situations in which beneficiaries are entitled to continuation of services pending a fair hearing decision when there is a disagreement between a provider and the MHP about the need for a service.

Rationale for Necessity: This regulation is necessary to assure that beneficiaries and MHPs are fully aware of their rights and obligations for aid paid pending a fair hearing and to clarify that nothing in these regulations changes those rights and obligations as provided by Title 22, Section 51014.2.

Subsection (a) explains that the time frame (normally 10 days from the date of notice) in which a beneficiary must file for a fair hearing to ensure continuation of services is not extended while a beneficiary is pursuing a complaint or grievance with the MHP. This is necessary to ensure that beneficiaries and MHPs are aware of this critical time frame.

Subsection (b) is necessary to establish the MHPs' obligation to continue to provide services for a beneficiary when the MHP denies a payment authorization request for specialty mental health services under specific circumstances. Most circumstances are covered by the cross-referenced Title 22, Section 51014.2 and are generally linked to a provider's request to continue services that were previously approved through the MHP payment authorization process. The subsection also establishes the MHPs' obligation to provide continuing services when the MHP denies an MHP payment authorization request to continue services that were initiated under an MHP policy of allowing a certain number of services to be provided without prior authorization.

Subsection (c) is necessary to make clear that references in Title 22, Section 51014.2 regarding Medi-Cal managed care plans apply to MHPs, since Section 51014.2 does not mention MHPs.

Article 3. Provider Problem Resolution and Appeal Processes.

Section 1850.305. General Provisions.

Specific Purpose: Section 1850.305 specifies the components of provider problem resolution and appeal processes under this chapter, including an informal problem resolution process within the MHP and a formal appeal process.

Rationale for Necessity: This regulation is necessary to provide an informal provider problem resolution process and to specify a provider's right to appeal a payment authorization decision made by an MHP. The regulation explains the procedure to help resolve disputes or other problems, to seek relief for denied payment for services by an MHP, and to further appeal to the Department under certain circumstances. This regulation is also necessary to specify the procedures and timelines an MHP and the Department must follow in reviewing the provider's appeal.

Subsection (a) is necessary to establish the requirement that each MHP shall have provider problem resolution and appeal processes and that MHPs are prohibited from discriminating against a provider for using the problem resolution or appeal processes.

Subsection (b) is necessary to describe the requirement of the MHP to notify all its participating providers with information about the provider problem resolution and appeal processes.

Section 1850.310. Provider Problem Resolution Process.

Specific Purpose: Section 1850.310 specifies the requirements for the provider problem resolution process.

Rationale for Necessity: Section 1850.310 is necessary to provide the minimum requirements for the informal provider problem resolution process.

Subsections (a) and (b) establish that the provider problem resolution process must accept verbal or written concerns, that the process must proceed quickly and that the process must be easy to use.

Subsection (c) establishes the MHP's obligation to inform providers that they may access the MHP's provider appeal process for problems covered by the appeal process at any time before, during, or after the informal problem resolution process.

Section 1850.315. Provider Appeal Process.

Specific Purpose: Section 1850.315 specifies the components of the provider formal appeal process.

Rationale for Necessity: Section 1850.315 is necessary to describe the required components of the provider appeal process.

Subsection (a) is necessary to describe under what circumstances a provider may appeal to an MHP and timelines for submission of appeals to the MHP. The time limit of within 90 calendar days to appeal an MHP decision of non-approval or failure to act on payment authorization was determined to be a reasonable time for the provider to pursue other less formal remedies and prepare the documentation necessary to file an appeal.

Subsection (b) is necessary to specify time frames for the MHP to inform the provider of its decision and its basis. The time period of 60 days for the MHP to respond to the provider was determined to be a reasonable amount of time to allow the MHP to reach a decision on these issues and prepare a response to the provider.

Subsection (c)(1) is necessary to require that MHPs use different staff to decide the appeal from those that denied the initial payment request, if the appeal concerns the denial or modification of an MHP payment authorization request, thereby removing conflict of interest concerns.

Subsection (c)(2) is necessary to require the MHP to notify the provider of any right of appeal to the Department, if the appeal is not granted in full.

Subsection (c)(3) is necessary to describe timelines for when a provider must submit a revised request for payment if the MHP decides to approve payment. The time period of 30 days has been determined as a reasonable time for the provider to prepare a revised request for payment authorization. A request for payment authorization after 30 days would create difficulty for the MHP to adequately track expenditures in a fiscally responsible manner.

Subsection (c)(4) is necessary to state the timelines for when the MHP must authorize payment if the appeal is decided in the provider's favor. The 14-day time limit for the MHP to process the payment request is consistent with similar timelines in this chapter.

Subsection (d) is necessary to explain the timeline whereby inaction by the MHP on a provider's appeal is considered denial of the appeal. This provision allows the provider to appeal to the Department even if the MHP fails to act in a timely manner. The timeframe of 60 days is the same period allowed for MHPs to respond to a provider's appeal.

Section 1850.320. Provider Appeals to the Department.

Specific Purpose: Section 1850.320 establishes the procedure and process whereby providers may appeal MHP decisions to the Department.

Rationale for Necessity: Section 1850.320 is necessary to explain that providers may appeal the denial or modification of request for payment authorization for emergency specialty mental health services and related administrative day services through the MHP's Provider Appeal Process to the Department. The subsection provides that hospitals may not appeal to the Department when the disputed issue is compliance with a mandatory provision of the contract between the hospital and the MHP that is permitted by Section 1820.220(g) and (h) and Section 1820.225(d)(5). This provision is necessary to establish the Department's responsibility to address issues related to the requirements of Subchapter 2, rather than to resolve unrelated contract disputes.

Subsection (a) is necessary to explain that hospitals and other providers may appeal to the Department separately unless the providers have agreed to another arrangement through contract terms with the MHP.

Subsection (b) is necessary to describe the procedures and timelines that apply to the provider when the provider appeals to the Department under subsection (e). The timeframes are consistent with similar time requirements in this section and provide adequate time for the provider to compile and submit supporting documentation.

Subsection (c) is necessary to establish the Department's obligation to notify the MHP and the provider of its receipt of a provider appeal and request documentation supporting the MHP position. The period of seven days to notify the MHP and provider of the request for an appeal has been established in order to expedite the appeal process as quickly as possible.

Subsection (d) is necessary to establish a time frame for the MHP to submit supporting documentation to be considered in the Department's review. The time period of 21 days has been determined to be a reasonable amount of time for an MHP to submit supporting documentation.

Subsection (e) is necessary to establish timelines for the Department to notify the provider and MHP of its decision and the reasons for the decision. The timeline recognizes the need to allow the MHP time to prepare documentation in support of its position as provided in (d), but also to ensure that the appeal process may continue if the MHP does not provide this documentation. This subsection also clarifies the provider's right to pursue other remedies if the Department does not render a decision within

established timelines. The timeframe of 60 days has been determined as a reasonable time required for the Department to review and process a provider appeal.

Subsection (e)(1) is necessary to establish the Department's authority to allow both MHPs and providers to present oral arguments to the Department.

Subsection (e)(2) is necessary to specify the timelines when a provider must submit a revised request for MHP authorization. The timeframe of 30 days is consistent with timeframes for submission of payment authorization requests in this Chapter.

Subsection (e)(3) is necessary to specify timelines for the authorization of a request for payment subsequent to the Department's decision in favor of the provider. The timeframe of 14 days was selected because it is consistent with other timelines in this Chapter for submission of documentation for MHP payment authorization. The MHP must, in some cases, submit corrected documentation to the fiscal intermediary to authorize the provider's payment request that was validated through the appeal process, if payment authorization is approved for other than all days on the original request.

Section 1850.325. Provider Appeal Process - Claims Processing.

Specific Purpose: Section 1850.325 specifies the procedures and timelines MHPs, Fee-for-Service/Medi-Cal hospitals, psychiatric nursing facilities, the fiscal intermediary, and the Department must follow when processing an appeal of a claims processing related payment issue.

Rationale for Necessity: This regulation is necessary to clarify the process that must be used to appeal specific types of claims processing-related payment problems. The timelines established are the timelines that already exist for these types of problems, specified in Section 1850.305 of these regulations.

Article 4. Resolution of Disputes between MHPs regarding MHP of Beneficiary.

Section 1850.405. Arbitration Between MHPs.

Specific Purpose: Section 1850.405 establishes the procedure and process whereby MHPs may arbitrate disputes regarding payment responsibility for beneficiaries.

Rationale for Necessity: This regulation is necessary to establish a formal arbitration process to determine final payment responsibility in cases where residence information in the MEDS file and/or MHP responsibility is disputed.

Subsection (a) is necessary to provide for a determination through arbitration that would establish the MHP of the beneficiary to be different from that in the Medi-Cal Eligibility Data System (MEDS).

Subsection (b) is necessary to allow two or more MHPs to develop an arbitration agreement to settle disputes regarding responsibility for payment authorization, and outlines the necessary components of such a process.

Subsection (c)(1) is necessary to outline the required method for MHPs to select an arbitrator to prevent conflicts of interest.

Subsection (c)(2) is necessary to establish the amount and method of payment to arbitrators. Payment is required in regulation to provide an incentive to all MHPs to participate in arbitration agreements with each other and, failing that, to increase the willingness of other MHPs to participate in the process provided under subsection (c). The level of payment is established at the lowest hourly rate listed on the United States Arbitration and Mediation Fee Schedule and the total time that may be billed is limited to ten hours. The Department has determined that using the lowest rate is reasonable in that the individuals acting as arbitrators are not professional arbitrators, although the responsibility they accept is comparable, and that ten hours should be more than sufficient to address the issues involved. Having these requirements in regulation will help prevent additional disputes over the amount of payment.

Subsection (c)(3) is necessary to establish the factual criteria on which the arbitrator(s) will make a decision. The criteria are based on applicable laws and also on common practices among county mental health departments, which make up the overwhelming majority of MHPs, but allow the arbitrators to use reasonable judgment when the facts do not clearly meet the criteria.

Subsections (c)(4)-(6) are necessary to provide timelines for the arbitration process that are consistent with other timelines in this chapter for notification, documentation submission, and decision.

Section 1850.415. Implementation of the Arbitrators' Decision.

Specific Purpose: Section 1850.415 provides for final payment adjustment provisions following a decision by an arbitrator.

Rationale for Necessity: This Section is necessary to establish the time period in which an MHP must implement the decision of the arbitrator. It also allows the Department to implement the decision if the MHP fails to act within the established timelines. The timeframe of 14 days was selected because it is consistent with other timelines in this chapter for submission of documentation for MHP payment authorization.

Section 1850.420. Provision of Medically Necessary Services Pending Resolution of Dispute.

Specific Purpose: Section 1850.420 specifies that medically necessary services will not be delayed pending resolution of a dispute over the county of responsibility for a beneficiary.

Rationale for Necessity: This Section is necessary to establish that, to prevent delays in needed services to a beneficiary, the MHP of the beneficiary as identified by the MEDS file will be responsible for provision, authorization, and payment of services until final responsibility is resolved.

Article 5. Resolution of Disputes between MHPs and Medi-Cal Managed Care Plans.

Section 1850.505. Requests for Resolution.

Specific Purpose: Section 1850.505 establishes procedures to resolve disputes between MHPs and Medi-Cal managed care plans regarding obligations under contract, law, regulation, or MOU.

Rationale for Necessity: This regulation is necessary to provide specific procedures through the Departments of Mental Health and Health Services to resolve disputes regarding the obligations of MHPs and Medi-Cal managed care plans for provision of services to beneficiaries.

Subsections (a) and (b) are necessary to establish that MHPs and Medi-Cal managed care plans with unresolved disputes must submit requests for dispute resolution to the department with which they contract.

Subsection (c) is necessary to provide an exception to the provisions of this regulation if the MOU established between the MHP and MCP includes an agreement to use binding arbitration as the means to resolve disputes between the plans. Binding arbitration, if agreed to by the parties, is a reasonable alternative to the dispute resolution process provided by this section, but would be meaningless without this exception.

Subsection (d) is necessary to provide timelines for submission for a request for resolution to the respective departments and the information that must be provided with the request. The timelines allow 15 days for a request when the dispute has already been through a resolution process at the plan level and 30 days when it has not. These timelines have been determined to be reasonable given the time normally required to identify a problem clearly and prepare documentation. When a dispute has already been initiated, less time is needed for these purposes. The timeline also reflects the need to ensure that the overall timeline for dispute resolution does not exceed the 90-day timeline for resolving state fair hearings.

Subsection (e) is necessary to describe the process and timelines that the departments will use to notify the other departments and the other affected parties, consistent with provider appeal timelines in this Subchapter.

Subsection (f) is necessary to provide timelines and notification standards for the submission of documentation in order to be considered in the resolution of the dispute, consistent with provider appeal timelines in this subchapter.

Section 1850.515. Departments' Responsibility for Review of Disputes.

Specific Purpose: Section 1850.515 provides the framework for the Departments of Mental Health and Health Services in the resolution process of disputes between MHPs and Medi-Cal managed care plans.

Rationale for Necessity: Section 1850.515 is necessary to establish the procedures for coordinated review of the disputes by both departments. The timeline of 30 days was selected to ensure a timely decision while still allowing the two departments reasonable time to review documentary material necessary to make a decision. The timeline also reflects the need to ensure that the overall timeline for dispute resolution does not exceed the 90-day timeline for resolving state fair hearings.

Subsection (a) specifies who may review the dispute and make recommendations to the departments.

Subsection (b) specifies that recommendations made by the departments can only be based on documentation related to statutory, regulatory, and contractual obligations of the plans.

Subsection (c) allows for oral arguments to be presented to the individuals deciding the dispute.

Section 1850.520. Departments' Decision.

Specific Purpose: Section 1850.520 provides for the process and timelines for issuance of the Departments' decision on disputes between MHPs and Medi-Cal managed care plans (MCPs).

Rationale for Necessity: Section 1850.520 is necessary to establish the procedures for coordinated review of the disputes by both departments.

Subsection (a) is necessary to establish a 30-day timeline for a decision from the date the documentation from the plans is complete. The timeline of 30 days was selected to ensure a timely decision while still allowing the two departments reasonable time to review documentary material necessary to make a decision. The timeline also reflects the need to ensure that the overall timeline for dispute resolution does not exceed the 90-day timeline for resolving state fair hearings.

Subsection (b) is necessary to outline the requirements in the written decisions by the departments, rates of payment if necessary, and any other actions required by the plans.

Subsection (c) is necessary to provide the Departments of Mental Health and Health Services authority to enforce the decision made through the dispute resolution process, including the ability to withhold funds.

Section 1850.525. Provision of Medically Necessary Services Pending Resolution of Dispute.

Specific Purpose: Section 1850.525 provides a process to continue the provision of medically necessary health care services to beneficiaries in the event of a dispute between an MHP and MCP.

Rationale for Necessity: This Section is necessary to assure that medically necessary services will continue for beneficiaries when there is a dispute as to which plan is responsible for provision of service(s).

Subsection (a) allows the two parties to agree to a mutually acceptable arrangement for the delivery of services.

Subsection (b) requires the MCP to provide services when the MCP believes the MHP should deliver the services and the MHP disagrees. This Subsection follows the principle that the party initiating the dispute has the primary responsibility to ensure continued service delivery. The MHP is required to provide specific consultation to the MCP regarding the treatment of the beneficiary.

Subsection (c) requires the MHP to provide services when the MHP believes the MCP should deliver the services and the MCP disagrees. This Subsection follows the principle that the party initiating the dispute has the primary responsibility to ensure continued service delivery.

Section 1850.530. Financial Liability.

Specific Purpose: Section 1850.530 provides a framework for establishing payment criteria for the MHP or MCP that is determined to be liable for payment of services rendered by the other party.

Rationale for Necessity: This Section 1850.530 is necessary to establish the financial liability of the unsuccessful plan in a dispute under this Article for services provided by the other plan.

Subsection (a) provides a process whereby financial liability is determined.

Subsection (b) establishes parameters for the rate to be assessed at the rates for the service established for the fee-for-service Medi-Cal program, except as provided in Subsection (c). These rates were selected because they can easily be identified by both parties and because they are rates that have been generally acceptable to Medi-Cal providers.

Subsection (c) establishes that the rate for services should be the rate claimed by the initiating party in the request for resolution unless the other party disputes the amount. If the rate is in dispute, the rate will be determined in accordance with Subsection (b).

Subsection (d) establishes timelines when a financially liable plan must reimburse the successful party.

Section 1850.535. Additional Conditions of the Dispute Resolution Process.

Specific Purpose: Section 1850.535 clarifies important issues that are not affected by the dispute resolution process.

Rationale for Necessity: Subsection (a) is necessary to clarify that action taken by the departments to resolve a dispute brought under this Section does not limit either department from taking appropriate action under its oversight authority.

Subsection (b) is necessary to clarify that this Article does not limit beneficiaries' ability to use the beneficiary problem resolution process and/or fair hearing process for issues related to the disputes brought to the departments under this Section. The Subsection also clarifies that when the decision of the departments under this section and the decision of a fair hearing are in conflict, the fair hearing decision will prevail.